Theoretically informed case study accompanying the film

Ammerudhjemmet - Norway

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QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/ammerudhjemmet

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a europeanwide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).

1. Short profile: Ammerudhjemmet: The innovation focuses on service users who are not able to live independently in their homes.

Specific innovative elements of Ammerudhjemmet

Network approach
Integrated approach to network analysis and integration for the service users. Aim: Connection of users (residents and their networks to the community).

Community based meeting place
Social service provider: open and embedded element of community and neighbourhood.

Cultural turn in long term care
Long term care moves from a medical approach to a cultural approach.

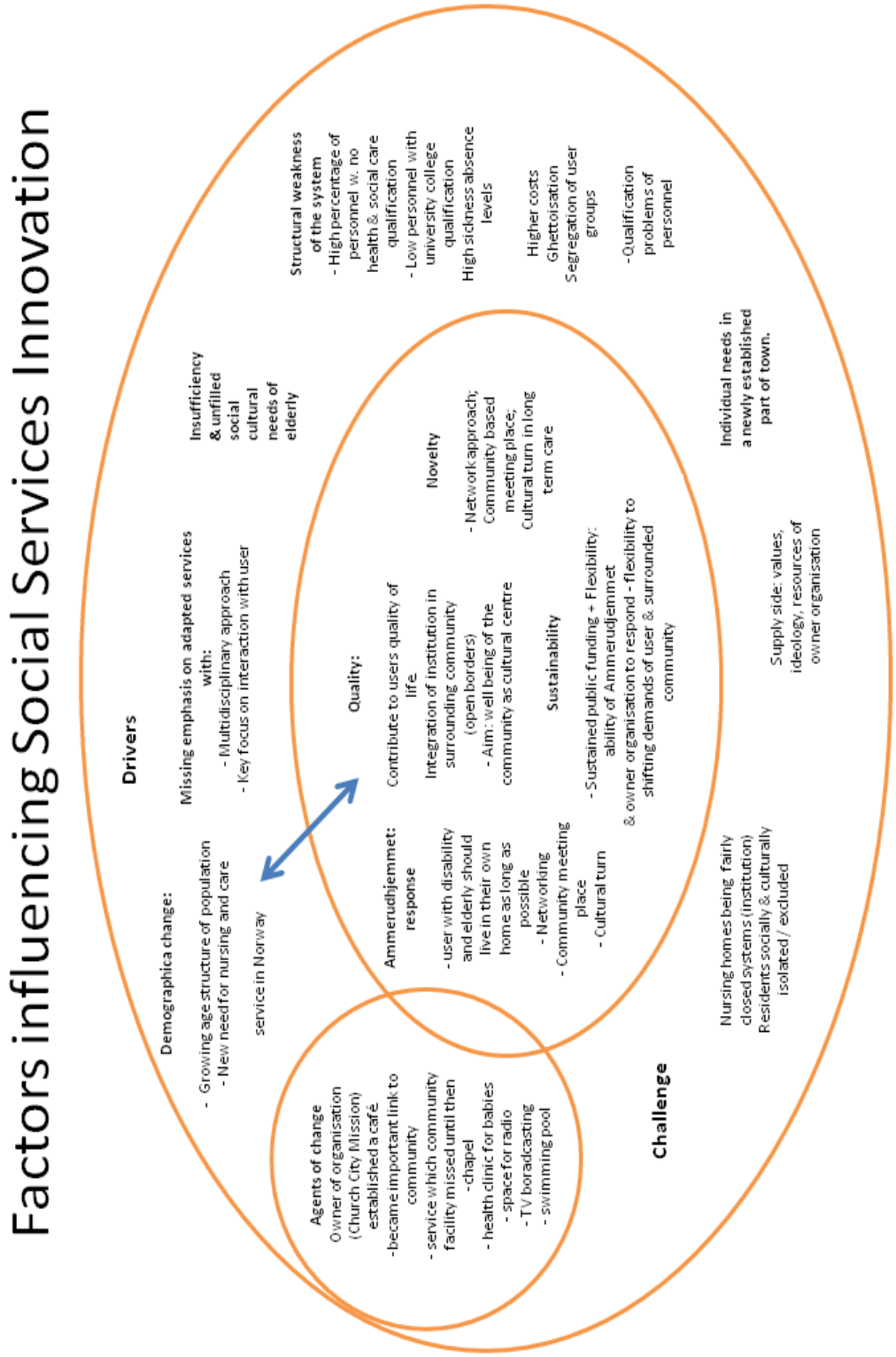
Key characteristics of the service

Organisation:
Ammerudhjemmet (owned by the Church City Mission, Oslo) is both a nursing home and a local community cultural centre. It is a private non Profit organisation, offering a total of 102 Beds and an additional 27 places for day care patients.

Principle:
The main ideology is to create and keep up an 'open nursing home model' in order to avoid a separation of users from the community ('ghettoisation'). Ammerudhjemmet is a special nursing home, in which inpatient & short term care is offered to people in need.

User groups:
User groups are elderly people (average age is app. 67 years) who need care. Some of them have health problems as well (for example, 80% suffer from dementia). The project is also open to people from the community. This way, the elderly are not separated but part of the society and able to participate.

Driver(s):
The reason for this innovative project is the unfulfilled social and cultural needs of elderly people living in nursing homes.


Factors influencing Social Services Innovation
Drivers
Demographica change:
- Growing age structure of population
- New need for nursing and care service in Norway
Missing emphasis on adapted services with:
- Multidisciplinary approach
- Key focus on interaction with user
Insufficiency & unfilled social cultural needs of elderly
Structural weakness of the system
- High percentage of personnel w. no health & social care qualification
- Low personnel with university college qualification
High sickness absence levels
Higher costs
Ghettoisation
Segregation of user groups
-Qualification problems of personnel
Quality:
Contribute to users quality of life
Integration of institution in surrounding community (open borders)
- Aim: well being of the community as cultural centre
Sustainability
- Sustained public funding + Flexibility: ability of Ammerudjemmet & owner organisation to respond - flexibility to shifting demands of user & surrounded community
Novelty
- Network approach; Community based meeting place; Cultural turn in long term care
Ammerudhjemmet: response
- user with disability and elderly should live in their own home as long as possible
- Networking
- Community meeting place
- Cultural turn
Agents of change
Owner of organisation (Church City Mission) established a café
-became important link to community
- service which community facility missed until then
-chapel
- health clinic for babies
- space for radio
- TV boradcasting
- swimming pool
Challenge
Nursing homes being fairly closed systems (institution)
Residents socially & culturally isolated / excluded
Supply side: values, ideology, resources of owner organisation
Individual needs in a newly established part of town.

2. Policy framework related to long term care in Norway

Principles / Guidelines	Key organisations and actors	Services provided by government	Expenditure, resources
1. **Decentralisation** from county and state to municipal level: 2. **Integration from special care to joint solutions:** Move to integrated home-based services instead of segregated special care services and institutions 3. **Deinstitutionalisation from institution to domiciliary care** services: blurring boundaries between nursing home and old people's home, community care housing and home care services (cf.HOD 2007:9)	- Legal Foundation for a comprehensive service at local level to the entire the population of the **municipality** municipal authorities from national county administration levels have the responsibilities (cf.HOD2007:7-9) - All Inhabitants shall have the same access to services, independent of social status, income and location. The organisational structure has three levels: the central state, the regional health care enterprise/county and the municipality (cf. Angell 2008:109). - The municipality and the regional health care enterprise has responsibility for the actual provision of health care services (cf. Angell 2008:109). - The provision of health services has traditionally been in the hands of the public sector in Norway (cf. Angell 2008:110). - Care of the disabled, mentally ill, and care of the elderly are covered at the local level by municipalities (cf.Angell 2008:104). - Some nursing homes and day care centres are managed by voluntary organisations, including church parishes and other church-based organisations, but funded by the municipalities (Angell 2008:112-113, cf. Szebehely 2005). Over the years, a larger share of health care services has been entrusted to non-profit/for-profit organisations. The new competitive regime (consequence of New Public Management ideas in the public sector) has had the (unintended) consequence that voluntary organisations have lost to private for-profit organisations. To strengthen the voluntary sector's position in the welfare services markets, the government has recently signed an agreement with representatives of the voluntary sector and the municipalities to improve the position of the voluntary sector against for-profit organisations in the health and social services market (Regjeringen et al. 2012). - The family is the basic unit in the provision of care. The family is still very important as a social support system, but the government and the municipalities have taken over the responsibility for the care of the elderly and children to a great extent (Angell 2008:114). During the past two decades there is a tendency that next of kin must take over more of the responsibility for the care of the elderly (Szebehely 2005).	**Legal milestones:** - Act of municipal health services, -nursing home reform -reform for persons with learning disabilities **Service characteristics** - The municipal long term care service is more extensive than the hospital sector - 200,000 users in care services 40,000 live in nursing homes 160,000 receive home care services in community care housing or their home (cf HOD 2007:6 ff) - The municipalities provide the social services. The personnel working in the sector are directly employed by the municipality (cf. Angell 2008:112). - Some day care centres and nursing homes are managed by voluntary organisations, including church parishes and other church-based organisations. They are funded by the municipalities and staffed by professionals. Very few enterprises involve commercial entrepreneurs (cf.Angell 2008:112).	1. Costs involved in the nursing and care sector (% of GDP): 3.1% = 2005 3.8% = 2025 6.1% = 2050 (cf.HOD 2007:10) - The municipal health service is financed through a combination of grants from the local government, retrospective reimbursement by the National Insurance Scheme (NIS) for out-of-pocket payments by the patients and services supplied (cf. Angell 2008:109). - The municipalities, in turn, receive block grants from the central government based on certain criteria (cf. Angell 2008:109). - The NIS is financed by contributions from employer taxes (40%), National Insurance contributions from employees, pensioners (about 30%), the state (about 30%) (cf. Angell 2008:109). -State grants and contribution rates are determined by the parliament (cf Angell 2008:109). The expansion of health and social care services has not reduced the amount of care, in terms of time, provided by families (cf.Angell 2008:111). Volunteers play a role in care not least in informal services, like visiting and practical services organised by voluntary organisations and voluntary service centres (Lorentzen 2010). Private funds play little role in funding care services.

3. The social, political and institutional context

3.1 Population/ Government

	Norway(2010)	EU27(2010)
Total Population in person:	4,858199	501,104164
Population projections 2010-2050	6,365895	524,052690
Proportion of population aged 65-79 years:	10.3 %	12.7%
Proportion of population aged 80 years and more:	4.5 %	4.7 %
Proportion of population aged 65 and over:	14.9 %	17,4%
Old-age-dependency ratio: (15-64 to 65+)	22.5 %	25,9 %
Projected old-age dependency ratio 2010-2050	40.29%	50,16%
Life expectancy at 60 (2009) in years Males: Females:	22 years 25.4 years	21.1 years 25.1 years
Expenditure on social protection (% of GDP) 2009	26.41%	29.51%
Expenditure on care for elderly (% of GDP) 2008	1.61%	0.41%
Pension expenditure projections (% of GDP) 2050	13.3%	12.3%

3.2 Information about the specific welfare state: Norway

There is a steady increase of expenditure in benefits in kind of social protection benefits (including social services), that shows the growing meaning in comparison to social protection benefit in cash. The table below presents the social protection expenditure of selected countries.

Social protection expenditure: Aggregated benefits and grouped schemes in millions of Euros

Time	Expenditure for social protection benefits in millions of Euros		Increasing benefits in kind	Part of benefits in kind of social protection benefits	
	1996	**2010**	**1996-2010**	**1996**	**2010**
EU 27	/	3,605,678.95	/	/	34.07%
Norway	32512.53	80833.67	152.74%	40.49%	41.16%
United Kingdom	262,859.71	478,281.18	124.56%	32.87%	40.56%
Germany	565,683.07	765,717.82	52.53%	30.79%	34.69%

Source: Own calculations based on EUROSTAT 2012

4. Challenges and drivers of innovation

Structural weaknesses of the system:

- High percentage of personnel with no health and social care qualifications, low percentage of personnel with university college qualifications, high sickness absence levels
- More emphasis on adapted services with a multidisciplinary approach and a key focus on the interaction with the individual user
- Weaknesses in the health service, the medical follow-up of long term care service users, patients in nursing homes, users of home care services and community care housing residents

Innovation*:* Ideas, criteria, levels and added values
The need for nursing and care services in Norway is expected to increase. The reason for this is the age structure of the population, especially the number of people over the age of 80 years (cf. Angell 2008:113).
The basic principle of care for the disabled and elderly people in Norway is that individualised support and services should be arranged in ways that enable care in people's home communities. Most of the municipalities (80%) now provide home care services 24 hours a day. Persons with disabilities and the elderly should have the opportunity to live in their own home for as long as possible (cf. Angell 2008:112).

The visualised case focuses on **three core Innovation** ideas in social services.
The innovations focus on such service users who are not able to live independently in their homes.
Ammerudhjemmet's vision is the idea that learning and development are for all people throughout their lives. Although life opportunities are limited, all aspects of life are present as long as one lives. That means that everyone should have a chance at a full life on their own premises, not least socially and culturally.

Network approach:
A core element of the highlighted service is the integrated approach to network analysis and integration for the service users. The aim is to connect the users, who are living in the project and their networks to the community.

Community based meeting place:
The second innovation represents a social service provider as an open and embedded element of community and neighbourhood. On a daily basis, people living in nursing homes tend to be socially and culturally isolated, excluded from the "vibrant life" of the community where the nursing home is located because of age-related frailties. Social and cultural interaction with the surrounding community is most often restricted to special occasions, with predominantly unilateral relationships: arrangements are primarily meant for the residents, and the events are organised as a visit to the institution. What Ammerudhjemmet aims at is for the institution to be a resource to the community, so that exchanges between the institution and its environment take place with a higher degree of mutuality (relationships marked by mutual resource dependency), be it children in the neighbouring kindergarten and school, youth, adults and elderly people who need a meeting place. In practice it means, for instance, is that the reception floor is an open, community space with a café and shops for personal services, and space for cultural events in the community. In practice it also means people living alone, especially elderly people, who regularly visit Ammerudhjemmet for such reasons, may be attended (worried about) if they "disappear"; staff take on network functions for people in the community. In this way the nursing home and its residents become more "naturally" integrated in the community than is usually the case.

Cultural turn in long term care:
The principle in long term care turns from a medical approach to also including a cultural approach. Meeting and fulfilment of general human needs are understood as including meeting and supporting the cultural needs and wishes of everyday life of users and community.

Agents of change

The need for nursing and care services in Norway is expected to increase because of the age structure of the population, especially the number of people over the age of 80 years (cf. Angell 2008:113).

The owner organization (Church City Mission) established a café, which became an important link to and resource for the surrounding community; serviced the community establishing facilities lacking elsewhere: chapel, health clinic for babies, space for radio and TV broadcasting; swimming pool etc.

5. Key innovative elements of this example

Field of service	Heath and Welfare
Establishment of organization	1970
Type of organization	Private non profit organization
Financing	Activities are to a great extend run by volunteers. Funded through private donations
Size of organization	More than 200 employees: nurses, one doctor, one priest, one cultural leader, 75 volunteers (80-90 years old), cooks, cleaning staff, one self-employed hairdresser, who is also a foot therapist and one volunteer coordinator 102 Beds, 27 places for day care patients, open, community space with a café and shops for personal services, and space for cultural events
Members and participation	Volunteers, close cooperation with the labour market business, community, hairdresser, café, library, swimming pool and pedicure
Contact Name of the innovative example Homepage	**Homepage:** http://www.bymisjon.no/no/Virksomheter/Ammerudhjemmet-Bo--og-Kultursenter/Hvem-e... **Organization:** Kirkens Bymisjon, Tollbugata 3, 0152 Oslo **Address:** Ammerudveien 45, 0958 Oslo **Contact person:** Øyvind Jørgensen **Phone:** (+47)23335323 **Email:** firmapost.ammerudhjemmet@bymisjon.no

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