National rollout of Healthy Life Centres in Norway to improve population health

Overview

Despite reporting some of the most favourable health outcomes in the WHO European Region, Norway faces a growing burden of chronic disease, largely attributable to unhealthy lifestyle choices and changing health behaviours.[1] In the early 2000s, following a series of unsuccessful piecemeal attempts to curb this trend, the Norwegian Directorate of Health launched a system-wide strategic plan to advance health promotion and disease prevention efforts in municipalities. The strategy took direction from the locally designed and successfully implemented Healthy Life Centre model. Healthy Life Centres are municipally managed facilities staffed by multidisciplinary teams of public health specialists working in coordination with primary care providers to support lifestyle and behaviour change. In 2012, following extensive piloting and review, national legislation formally endorsed municipal action to implement the model across the country.

By 2014, over 180 Healthy Life Centres were established, covering approximately half of Norway's 428 municipalities with their services. The implementation rate reflects the benefits of technical and financial resources invested nationally, as well as regional motivation and capacity to adapt the model to local needs. At present, a full-scale evaluation led by the Directorate of Health is planned which will help determine future directions for the initiative.

Problem definition

Overall, Norway's 5 million inhabitants report positive health outcomes. Life expectancy was 82 years in 2012, above the WHO European Regional average of 76, and the gap between overall life expectancy and healthy life years was half that of the European Union average.[2] However, over the past decade the increasing prevalence of overweight and obesity and rising alcohol consumption have contributed to less favourable trends for chronic conditions, such as cardiovascular disease, type 2 diabetes and certain cancers (Box 1). In the context of growing chronicity and multi-morbidities with complex treatment needs, a more proactive approach to services delivery was needed to help contain health care costs and high rates of sick leave.2

Box 1
What challenges did the initiative aim to address?

- Shifting lifestyle trends and rise in less healthy behaviours within the population.
- Growing burden of chronicity, notably rising rates of cardiovascular disease, type 2 diabetes and certain cancers.
- Rising economic pressures such as the inability of the public sector to cope with increased demand for chronic needs, as well as high rates of sick leave.

Health services delivery transformations

Timeline of transformations

In the early 2000s, in an effort to curb increasing rates of chronicity, the Norwegian Directorate of Health experimented with strategies to advance health promotion services. These attempts however were met with limited success (Table 1). By the mid-2000s, the locally conceived idea of Healthy Life Centres (in Norwegian, Frisklivssentraler) began attracting national attention.* Following a favourable review of the approach and a successful pilot study across five counties, the Directorate of Health issued a national recommendation in 2006, advising municipalities to take concerted action to increase their health promotion efforts and endorsed Healthy Life Centres as

the recommended approach for achieving this goal. Ten years after the initiative was first piloted, a total of 251 municipalities and city districts (approximately half) have Healthy Life Centres that are now operational and providing health promotion services.

Description of transformations

Selecting services. Taking direction from the population's increasing chronic care needs, Healthy Life Centres have broadened the scope of local health promotion services to include a wide range of interventions extending to smoking and alcohol cessation programmes, cooking classes and nutrition counselling, courses for coping with mental health challenges and diabetes management. The specific services provided by Healthy Life Centres are determined at the municipal level to ensure a package of services tailored to local needs.

Designing care. Throughout the early 2000s, the standard preventative services provided to patients by general practitioners were described as generic and brief. However, following the introduction of Healthy Life Centres, patients can now be referred to the nearest facility for highly personalized preventive services. Care plans are formulated following a standard 12-week programme, using the principles of motivational interviewing to design programme goals with the active participation of the individual to match activities with their needs and personal preferences. Participants typically complete two or three programme cycles before fully establishing their desired behaviour change and exiting the care plan.

Organizing providers. Working in close coordination with primary care providers to facilitate referrals, Health Living Centres have networked a variety of health professionals including physiotherapists, nurses, personal trainers, psychologists and nutritionists; pooling expertise for the delivery of a comprehensive range of services onsite. At the end of the 12-week programme, patient progress is reported back to general practitioners and, if further follow-up is warranted, patients can re-enter the programme. If necessary, patients may be given referrals to external providers for services not available at their local Centre.

Managing services. Healthy Life Centres are funded primarily through municipal health budgets. Healthy Life Centres generally require office space, a consultation room and access to outdoor exercise facilities. Smaller municipalities coordinate or partner with neighbouring Centres to ensure coverage in their area. Through partnerships with other public facilities, such as schools and community centres, it has been possible for Centres to minimize costly infrastructure expenses. Some services offered require a small monetary input from patients to cover expenses, such as ingredients for cooking classes; these fees are considered nominal and not limiting of access. Centres have a specified scheme of questions to complete for each participant at the beginning and end of the programme, ensuring necessary data for managing the general operations of facilities is generated.

Improving performance. All professionals operating within the Centres have undergone training on motivational interviewing to equip them with the skills needed

Table 1
What were the chronological milestones for the initiative?

1998	First Healthy Life Centre opened in municipality of Modum Kommune by local administration in response to local health needs.
Early 2000s	National Directorate of Health explored ways to improve disease prevention services as positioned in the 2002-2003 Prescriptions for a Healthier Norway White Paper.
2004	Evaluation of programmes including the introduction of green prescriptions and the Healthy Life Centre model by the Directorate of Health led to the decision to pilot Healthy Life Centres in five counties.
2006	National Strategy to Reduce Health Inequalities published by the Directorate calling for further interventions and follow-up programmes to Healthy Life Centres.
2008-2011	Legislation drafted to officiate a renewed focus on prevention and early intervention for chronic disease.
2011	Guidelines for Municipal Healthy Life Centres published by Directorate.
2012	New public health legislation enacted requiring health promotion services be provided in some capacity across all municipalities; Healthy Life Centres recommended as the ideal practice.
2013	Revised edition of the Guidelines for Municipal Healthy Life Centres published.

to support and strategically guide patients through the programme. In addition, professionals receive courses on a range of topics such alcohol, nutrition, or sleep counselling, to expand their scope of practice and increase their awareness of the multidisciplinary environment they work in.

Engaging and empowering people, families and communities

This services delivery transformation has worked to support behaviour change in the population for improved health outcomes by placing a strong emphasis on engaging and empowering the individual service user. To address underlying causes of chronic disease, rather than merely treat symptoms, individuals are called upon to be active agents in promoting their own health. Healthy Life Centres can be accessed either through a prescription from a primary care provider or directly by the individual. In either case, the individual decides to use the service of their own volition. In an initial meeting with a counsellor, participants' medical history, personal information and desired behaviour changes are discussed. Using motivational interviewing to empower the participant, a set of goals and a personalized action plan are designed in close partnership with participants; family members are also welcome to participate in the process.

As a locally led effort, in many municipalities, Centres have managed to embed themselves within both the health system and local community, becoming successful and sustainable sources of wellness and health education.

Table 2
How was the delivery of health services transformed through the initiative?

Before	After
Selecting services	
Lack of effective disease prevention or health promotion services; traditional services fail to adequately address rising burden of chronic disease.	Increase in continuum of services across the life course with health promotion services required by law; comprehensive range of health promotion services available through Healthy Life Centres.
Designing care	
Patients receive brief, generic information from general practitioners and are issued green prescriptions for diet and physical activity; limited follow-up care to support healthy behaviour change provided.	Patients receive highly personalized care plans and intensive follow-up care in Healthy Life Centres; flexible care planning process based on principles of motivational interviewing is dictated by patient needs and goals.
Organizing providers	
Primary care providers are responsible for preventive care, with limited time and training in health behaviour change for the meaningful provision of disease prevention and health promotion services.	Primary care providers refer patients to multidisciplinary teams within Healthy Life Centres; patients' progress relayed back to primary care provider to ensure continuity of care; primary care providers contacted if individuals access Healthy Life Centres directly.
Managing services	
Preventive services delivery sole responsibility of primary care; no dedicated resources for health promotion.	Partnerships between primary care and Healthy Life Centres delegate services delivery to municipally funded Healthy Life Centres which are equipped with necessary resources for health promotion activities; individuals provide nominal resources for some activities.
Improving performance	
Primary care providers lack necessary training to effectively motivate behaviour change in patients.	Professionals in Healthy Life Centres receive training in motivational interviewing and a variety of health promotion topics.

Table 3
How has the health system supported transformations in health services delivery?

System enablers	Example
Accountability	• Legislative changes require municipalities to provide health promotion services in some capacity.
Incentives	• Directorate of Health provides start-up funds to municipalities establishing Healthy Life Centres, incentivising this service over others.
Information	• Pilot programme prior to rollout of the Healthy Life Model provided evidence of effectiveness and helped refine implementation guidelines. • Directorate of Health established reporting requirements for Healthy Life Centres to allow monitoring and evaluation of activities; Centres complete set scheme of questions for each participant at the beginning and end of individuals' 12-week programme.
Innovation	• Research and development supported by the Norwegian Knowledge Centre for Health Services.

Educational campaigns on health promotion have further supported the initiative by increasing population health literacy and awareness of the service and its success.

Health system enabling factors

While the concept of Healthy Life Centres was derived from municipal actions, scaling-up the initiative and embedding it within the health system was a result of macro level efforts led by the Directorate of Health. National guidelines developed based on pilot studies for the approach and legislation enacted by the national government in 2012 requiring municipal provision of health promotion services, for example, fostered necessary institutional arrangements at scale.

Sustainable financing has been made possible through municipal funding, with services provided at Centres forming part of the basic benefits package. Initial start-up costs have been supported by the government as an incentive for municipalities to establish the Healthy Life Centre model. On-going research to further advance the evidence base on the significance of behaviour change for health improvement is led by the Norwegian Knowledge Centre for Health Services.

Outcomes

Improved health outcomes as a result of Healthy Life Centres have been demonstrated in a small-scale pilot study conducted in 2004 (Box 2). A larger, formal evaluation of the intervention being led by the Directorate of Health is planned for the coming year with data collection currently on going.

Box 2
What were the main outcomes of the initiative?

- Between 1998 and 2014, 183 Healthy Life Centres were established providing a comprehensive package of health promotion services to approximately half of Norway's municipalities.
- A pilot study on Healthy Life Centres has shown remarkable success in the prevention of chronic disease, as well as reductions in health expenditures.
- A study of Healthy Life Centres in the municipalities of Nordland and Buskerud showed referral to Centres can support improved fitness, weight loss and increased self-perceived health.

Change management

Key actors

Local municipal action first spurred the development of Healthy Life Centres and, since their conception, leadership at the national government level, along with support and cooperation from a variety of different actors (Box 3), has facilitated their widespread introduction. While the national government has steered the effort to introduce Healthy Life Centres through legislation, incentives and recommendations, adoption of the model ultimately rests on the motivation of local actors who remain free to seek adapted or alternative approaches for improving local population health.

Box 3
Who were the key actors and what were their defining roles?

- **Municipality of Modum Kommune**. Invented the Healthy Life Centre concept through grassroots action

in response to local health problems.

- **Directorate of Health**. Spearheaded the national rollout of Healthy Life Centres; led a pilot study for the initiative, developed and published implementation guidelines, mandated municipalities provide health promotion services and financially incentivized implementation of Healthy Life Centres; currently planning a large-scale evaluation of Healthy Life Centres.
- **Municipal governments**. Responsible for providing health promotion services in some capacity; allocate funding to Healthy Life Centres and support their set-up and running.
- **Healthy Life Centre teams**. Multidisciplinary teams of health professionals co-located within Healthy Life Centres provide a comprehensive set of health promotion services in close partnership with Centre participants and primary care providers.

Initiating change

Community health leaders designed the first Healthy Life Centre in response to high rates of sick leave they observed in their municipality. Through meetings and advocacy efforts to engage the support of the municipality, grassroots action helped establish this first centre as an important community resource and its successes generated national attention. With evidence of success deriving from the pilot example in the municipality of Modum Kommune, the government had a strong evidence base supporting the scale up of the approach. While government commitment was integral to launching the momentum for a country-wide effort, the model itself and its implementation continue to remain dependent on community driven efforts in response to local contexts.

Implementation

The distributed leadership approach allowed municipalities the autonomy to implement their own initiatives, engage local leaders in the design process and create local ownership over the Healthy Life Centre model. Strong teamwork between health professionals in the Centres combined with collaborative partnerships with participants contributed to the successful running of activities. Guiding participants through change is an important part of the process requiring unique leadership skills. Generating support from providers proved critical for securing referrals. While some areas were successful through regular meetings with providers to educate them on the benefits of the programme and gain their support through referrals, in other areas providers were less engaged and, therefore, less likely to refer patients.

Moving forward

In 2014, Healthy Life Centres provided coverage to approximately half of Norway's 428 municipalities, with hopes to further expand as the Directorate of Health continues to support the development of Centres across the country. Further adoption remains dependent on leadership from local municipalities to take advantage of the incentives and tools put in place by the Directorate. A full-scale evaluation planned by the Directorate may offer insight for future directions.

Highlights

- Government commitment to address the growing burden of chronic disease through strengthening health promotion and disease prevention services provided a platform for change.
- A local initiative to address services delivery challenges proved the most appropriately responsive method to tackle similar challenges observed in other municipalities.
- Actions by the national government to steer the health system towards a common direction capitalized on local solutions.
- A structured approach to the rollout of the model of Healthy Life Centres from the outset ensured accountability and system-wide evaluation.
- Collaborative partnerships between primary care providers and Healthy Life Centres have been integral to streamline service use and facilitate continuity of care.

1 Norwegian Knowledge Centre for Health Services. (2011). *Effects of organized follow-up on behavior that may increase risk of disease in adults – executive summary* [English]. Norwegian Knowledge Centre for Health Services.

2 Ringard, A., Sagan, A., Saunes, I.S., and Lindahl, A.K. (2013). Norway: health system review. *Health Systems in Transition; 15*(8): 1-162.

* The Norwegian health care system can be characterized as semi-decentralized, whereby municipalities are responsible for primary care services and have the authority for organizing health services delivery in their jurisdiction. For more details on the organization and governance see: Ringard, A., Sagan, A., Saunes, I.S., and Lindahl, A.K. (2013). Norway: health system review. *Health Systems in Transition; 15*(8): 1-162.