Tidsskriftet
DEN NORSKE LEGEFORENING

Wastefulness

FRA REDAKTØREN

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According to the prime minister, we cannot afford to expand intensive care capacity without taking resources from other patient groups. The strange thing is that in other respects, money seems to be no issue.

Photo: Sturlason

'This is a priority,' Prime Minister Erna Solberg recently stated when confronted with the fact that Norway has approximately five intensive care beds per 100 000 inhabitants, which is less than one-half of the average in the OECD countries (1). 'Should we build a healthcare system with more intensive care beds than we need in a normal situation, or should we use the system to work with the chronic, long-term diseases? After all, health service resources are limited (…). The question is whether intensive care capacity is the most important aspect to improve in the Norwegian healthcare system,' she continued (2).

At the time of writing, a record number of patients are being admitted with the coronavirus in South-Eastern Norway Health Authority, and many intensive care units are overburdened. Eleven coronavirus patients proved too many for Akershus University Hospital, which has only two intensive care beds per 100 000 inhabitants. In the course of three weeks in March this year, 19 seriously ill COVID-19 patients on ventilators had to be moved between the hospitals in South-Eastern Norway Health Authority, most of whom from Akershus University Hospital (3).

The pandemic we are in now is not a normal situation. But the capacity problems in the intensive care units nationwide are exactly that

The pandemic we are in now is not a normal situation. But the capacity problems in the intensive care units nationwide are exactly that. In 1999, the Norwegian Board of Health Supervision undertook a review of the operational conditions in the intensive care units. All the hospitals had capacity problems, and lack of nurses was described as the main problem.

It was pointed out that understaffing increases the risk of wrong treatment, and that requirements for quality and safety can be difficult to meet (4).

Since then, intensive care doctors have continued to warn about capacity problems and their fears that deaths may occur as a result (5). The daily work is characterised by too few intensive care beds, leading to difficult prioritisations regarding which patients can be treated in the unit. The lack of non-ICU monitoring beds means that patients who could have managed at a lower level of care occupy intensive care beds. When no intensive care beds are available, there is a risk that non-emergency surgeries must be postponed. Such are the ramifications of the dismantling that Norwegian hospitals have gone through in recent decades. The number of somatic beds has been halved since 1980, even though the population has increased by one million (6).

It is assumed that the need for intensive care beds will increase significantly, in pace with an increasing proportion of older people (5). Furthermore, the need for far better preparedness in terms of intensive care beds was already well known after the swine flu epidemic in 2009, but ten years later the intensive care capacity remained at the same level (1). Since the start of the coronavirus pandemic one year ago, the number of intensive care beds has not increased – it has in fact been further *reduced* (7).

Even under normal conditions, the intensive care units struggle to find enough nurses and have come to rely on contracting them from manpower agencies abroad. The pandemic has shown that the lack of intensive care nurses is the most pressing problem. To be sure, they have been applauded over the last year, but the nurses feel they have been stabbed in the back. The wage bargaining round in 2020 gave them a wage increase of a miserly 1 400–1 900 kroner per *year* (8).

The hospitals have seen an influx of overpaid consultants with no healthcare background who are there to tell health personnel how to 'work smarter'

'We need to get better at using the available resources,' the prime minister has stated (2). However, this obviously does not apply to everybody. The hospitals have seen an influx of overpaid consultants with no healthcare background who are there to tell health personnel how to 'work smarter'. For several months, Nordland Hospital Trust paid consultants NOK 1600 per hour, i.e. an amount corresponding to the specialist nurses' annual wage increment, to design duty rosters that turned out to be completely impractical (9). The merger of Oslo University Hospital led to approximately NOK 3 billion in consultancy costs (10). To put it mildly, the consultants were off the mark in their conclusion that the merger would produce annual cost savings of NOK 900 million (10). The cost of the patient record and coordination solution Akson was originally calculated at NOK 11 billion, but is now estimated to exceed NOK 22 billion (11). In 2018, South-Eastern Norway Health Authority was sharply criticised by the Office of the Auditor General for having spent NOK 6.2 billion on the prestige project Digital Renewal, which turned out be largely useless (12). The x-ray system that cost half a billion kroner had so many serious faults that it finally had to be abandoned. In 2016, South-Eastern Norway Health Authority thereby won the not-so-coveted Wastefulness Award, which is given out each year by the Taxpayers Association for public profligacy with taxpayer funds (13).

The wastefulness seems bottomless when it comes to prestige projects. The politicians repeatedly choose to support the bureaucrats in their mistaken prioritisations of healthcare funds, and there is a steadfast reluctance to listen to healthcare personnel who are at the frontline. It is this which has caused the dismantling of our hospitals. A sufficient number of hospital beds and an appropriate intensive care capacity have lost out in the battle for healthcare funding.

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Published: 13 April 2021. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.21.0283