
We have no available beds

OPINIONS

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Where should the coronavirus patients go?

'All hospital beds in Norway are full.' This was announced by divisional director, Norwegian Director of Health, Svein Lie on March 6 [\(1\)](#) – before any coronavirus patients had been admitted to hospital in Norway. The tragic fact is that he is right. There is no buffer. In most Norwegian hospitals, the occupancy rate is around 100 %, and even more in many places. Daily discussions are held at the hospitals about where to place patients who have been admitted and cannot be sent home. Stories of despair have been an ongoing presence in the press for a long time [\(2, 3\)](#), and reports of concern have been sent without anything being done. On the contrary, every time an excellent new hospital has been built, the capacity has been reduced. In 1980, there were approximately 22 000 somatic beds in Norwegian hospitals. We are now down to less than 11 000 [\(4\)](#). Norway is one of the countries in Europe with the fewest hospital beds per capita.

Capacity has steadily been reduced under various governments [\(3\)](#). This has taken place contrary to the OECD's recommendation of a maximum average occupancy rate of 85 %, specifically with the intention of safeguarding a safe margin to cope with unforeseen events that put further pressure on hospitals. The new hospital in Trondheim has over 200 fewer beds than the one it replaced. The same was seen in Østfold and Akershus, and will now be repeated in Drammen, despite the fact that the use of corridor beds was commonplace even before the epidemic. In Oslo, one has to hope that the senseless, disastrous plan to close down Ullevål Hospital in favour of a mammoth hospital at Gaustad will be shelved. This will only exacerbate the capacity problems throughout southern Norway [\(5\)](#).

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We have long since passed 'the safety tipping point in hospitals' in Norway (6). Even the youngest members of society are not being spared: in Bergen, a new women's health clinic is being planned, where the intention is to send home a large proportion of new mothers and their babies 4–24 hours after the birth, despite concerns expressed by professionals about the adverse effects this can have on a mother and her new baby (7).

We have to wonder what these decisions are based on. Efficiency, logistics and finances seem to carry more weight than safe patient care. The decision-makers have paid more attention to the words of highly paid consulting firms with unrealistic calculations about the future and ministerial bureaucrats than to the professionals in the hospitals (8).

The under-capacity at hospitals has serious consequences. The media have reported a number of deaths (9, 10), and the newspaper VG published an article about 1 546 older patients being discharged from hospitals in the middle of the night, 400 of whom were over the age of 90 (2). A new, large-scale epidemiological study at NTNU indicates that there is a strong correlation between the increasing pressure on hospitals and the rise in mortality rates (11).

The intensive care capacity in Norway is average for Europe (12). If the capacity is to be increased, regular postoperative areas need to be adapted for use as intensive care units and nurse anaesthetists need to be retrained. However, it is the 'ordinary' patients who have to pay the price, those who have other illnesses and who are currently overstressing the hospitals. These problems will now hit us like a ton of bricks due to the unrelenting reduction in hospital beds over so many years.

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If we are to accommodate the COVID-19 patients who are so ill that they need hospital treatment, we must cut back on all planned activity at the hospitals. It is not going to be easy. Many operations are already performed as outpatient surgery. In the past, many of the hospital patients were 'healthy', but that is no longer the case. Cancelling day surgery can free up personnel but it does not free up beds. The current hospital patients are very sick and need the beds they are using. And our intensive care units are already full of 'ordinary' patients with organ failure for other reasons. They cannot just be turfed out, or can they? Could there be talk of deferring patients with serious illnesses as well? Will age be used as a determining factor?

One of the most disheartening things is that operations are now being cancelled due to a lack of sterile gowns and face masks. These need to be saved for staff treating COVID-19 patients. We were warned almost three months ago and

have had ample opportunity to procure personal protective equipment, as they did in several Asian countries. Unfortunately, we did not take the warnings seriously.

Politicians and bureaucrats have shown a depressing lack of foresight and realism. Many colleagues have seen this coming. Why have we not protested more vigorously? Maybe we now understand that the reduction in capacity must be stopped?

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