Summary

Cottage hospitals, local medical centres, and district medical centres encompass various models of decentralised specialist healthcare services, involving collaboration between municipalities and regional health authorities. The mapping shows variation in organisation, service provision, and funding. Clear agreements, effective collaboration, and local adaptation are common characteristics among the units identified as particularly successful. The services are perceived as beneficial for patients, and several also highlight their contribution to strengthening local medical preparedness. At the same time, challenges are noted related to financial sustainability and the risk of unclear division of responsibilities. This has partly already led to new ways of working and changes in the distribution of functions.

The Health Reform Committee was appointed in August 2025 and has been tasked with assessing and proposing different models for the future organisation, governance and financing of the health and care services. In light of the Committee's work, there is a need for more systematised knowledge about models in which decentralised specialist health services are co-located with municipal services.

On behalf of KS, Oslo Economics has therefore, in collaboration with Anette Fosse (National Centre for Rural Medicine), Siv Fladsrud Magnussen (Centre for Care Research, NTNU) and Tor Iversen (University of Oslo), mapped the extent of cottage hospitals, local medical centres (LMCs) and district medical centres (DMCs). The mapping covers how these units are organised and the experiences associated with this type of service provision.

The findings indicate that there is no single model that clearly stands out as the "best". Rather, several models may perform well and function effectively within their local context. The models have evolved in line with medical developments and the availability of resources. Experience suggests that local conditions and traditions of collaboration influence the extent to which the services are perceived as successful. A recurring characteristic of cottage hospitals, LMCs and DMCs with positive experiences is the presence of clear agreements on responsibilities and financing. Where such agreements are in place, the evidence suggests that the models can be adapted to local conditions and needs, and that they can deliver benefits for patients, particularly in rural areas with long distances to hospitals.

Figure 1: Collaboration and coordination in cottage hospitals, local medical centres and district medical centres

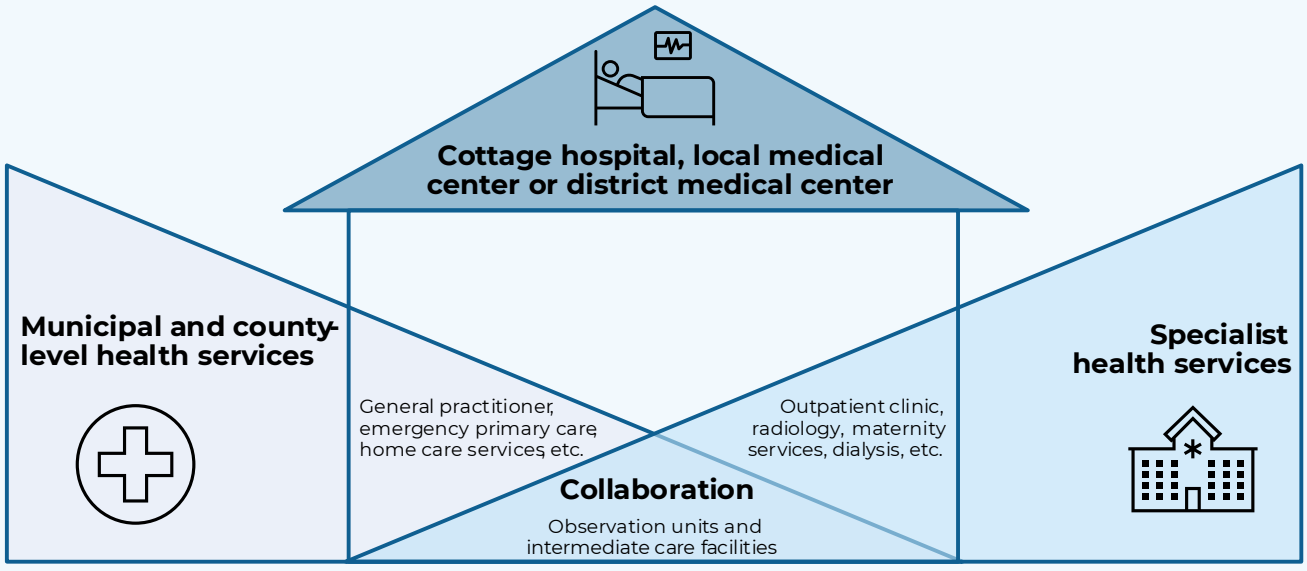


Illustration: Oslo Economics based on Aasheim & Kleppen (2012).

Method

To address the study's research questions, we conducted a document review, surveys of chief municipal medical officers in host municipalities for cottage hospitals, local medical centres and district medical centres (18 respondents), and managers of these units (19 respondents), as well as 11 qualitative interviews with managers of cottage hospitals, DMCs and LMCs, and with chief municipal medical officers in the host municipalities.

About cottage hospitals, local medical centres and district medical centres

The terms cottage hospitals, local medical centres (LMCs) and district medical centres (DMCs) are not defined unambiguously. Municipalities and hospitals use these terms to describe different types of health services, including services that are similar in terms of content and organisation, as well as services that differ substantially.

In particular, the terms local medical centre and district medical centre are often used interchangeably. They generally have in common that they are organised through collaboration between municipalities and regional health authorities, and that they provide decentralised health services in areas with long travel distances to hospitals. Cottage hospitals differ from DMCs and LMCs in that they always include inpatient beds, often referred to as cottage hospital beds, which may be used for patient observation, stabilisation prior to transport to hospital, or post-treatment following hospital admission.

Location and service provision

Our mapping shows that, as of 2026, there are approximately 35 cottage hospitals, LMCs or DMCs in Norway. The exact number depends on the definition applied, including the degree of collaboration and co-location between specialist health services and the municipal health and care services, as well as the scope of specialist services provided.

Findings from the surveys and interviews show that service provision varies across units. We identify examples of units that offer inpatient beds only, units that offer day treatment only, and units that offer outpatient consultations only. Several units provide a combination of different types of stays. There is also variation in the content of outpatient services. The mapping, based on a review of the units' websites, shows that the most common outpatient services are dialysis (14 units), radiological examinations in the form of diagnostic imaging (X-ray, CT and/or ultrasound) (13 units), laboratory services (10 units), dermatology and phototherapy (9 units) and/or gynaecology (5 units). Three units have maternity units, while three have oncology outpatient clinics. Some units also provide services for patients with mental health conditions, either in the form of child and adolescent psychiatry (four units) and/or adult psychiatry (one unit).

Administrative responsibility and employer responsibility

Among the cottage hospitals, LMCs and DMCs represented in the survey of managers of these units, it is most common that the host municipality holds the administrative responsibility for operations (Figure 2). The survey also shows that employer responsibility is often held by the host municipality, both for staff delivering municipal health services and for staff delivering specialist health services (Figure 3).

Among the unit managers who reported that the host municipality holds employer responsibility for health personnel delivering specialist health services or municipal health and care services at the cottage hospital, LMC or DMC, five out of nine managers stated that this personnel has a permanent presence at the unit. One manager reported that the employees have a rotational or ambulatory affiliation, while three reported "other" arrangements and elaborated on this in open-ended responses. Managers who reported that the regional health authority holds employer responsibility for health personnel delivering specialist health services stated, in open-ended responses, that either all or some of the physicians alternate between working at other units within the regional health authority and at the cottage hospital, LMC or DMC.

Financing models between regional health authorities and municipalities

Findings from both the survey and interviews show that different financing models are used. Five out of twelve unit managers of cottage hospitals, LMCs and DMCs reported that the regional health authority purchases services from the municipality in order to provide its services, while nine out of

twelve reported that the municipality does not purchase services from the regional health authority in order to provide its services at the cottage hospital, LMC or DMC.

The interviews showed that, in some cases, it is unclear which party is responsible for financing when there is a need for major investments in medical-technical equipment. Such investments are necessary to maintain or further develop the services, but the agreements underlying these services do not always clearly specify whether the costs are to be borne by the municipality or by the regional health authority.

Seven out of twelve managers reported that they experience the financing model as financially sustainable to a small or very small extent. In open-ended responses, managers particularly pointed out that the host municipality incurs indirect costs that are to a limited extent captured in current financing models, and which are difficult to document and incorporate into rent levels or other cost-sharing mechanisms. It was also noted that some financing models involve fixed allocations that are only to a limited extent adjusted for utilisation or changing needs over time. Several noted that, over time, municipalities have been assigned an increasing number of more demanding responsibilities, partly as a result of earlier hospital discharges of patients with greater and more complex follow-up needs, without corresponding adjustments in funding.

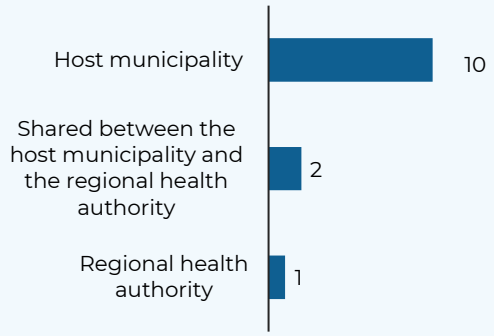
Collaboration between the regional health authority and the municipalities

Responses from the survey of managers show that there is variation in whether joint collaboration arenas have been established for staff from municipal services and specialist health services. Four out of ten managers reported that such arenas have been established, while six reported that this is not the case.

The interviews elaborate on this and show that collaboration is to a large extent organised in different ways. At some centres, permanent and formalised meeting forums between the municipality and the regional health authority have been established. At Klinikk Alta, for example, regular collaboration meetings are described between the clinic's management, municipal management and the coordination officer for cooperation, with an approximately quarterly frequency, providing a forum for dialogue. At Hallingdal sjukestugu, collaboration arenas have also been established at both administrative and clinical levels, with regular meetings and clear structures for dialogue between the levels.

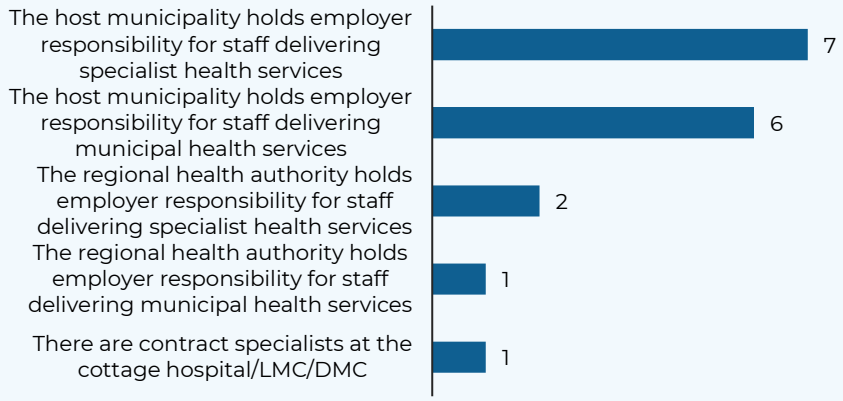
In other units, collaboration appears to be more informal and person-dependent. Several informants reported that co-location lowers the threshold for professional interaction, but that this is not supplemented by formalised arenas for shared learning.

Figure 2: Who holds administrative responsibility for the operation of the cottage hospital/LMC/DMC?



Source: Survey of managers at cottage hospitals/LMCs/DMCs. N = 13

Figure 3: Who holds employer responsibility for health personnel?



Source: Survey of managers at cottage hospitals/LMCs/DMCs. *Multiple-response question*. N = 9

Cost sharing between collaborating municipalities

The results from the survey of chief municipal medical officers in host municipalities for cottage hospitals, LMCs and DMCs show substantial variation in how costs are shared among collaborating municipalities. No respondents reported that costs are distributed equally or based exclusively on actual use. The most commonly applied models involve combinations of base funding and allocation based on population size or utilisation.

In some collaborations, costs are shared only for specific services, while remaining costs are borne by the host municipality and the regional health authority under separate agreements, for example based on floor area and use. In other cases, operating budgets or accounts are allocated according to a fixed share combined with population-based allocation, or municipalities pay an annual reimbursement to specialist health services based on expected use of cottage hospital beds or municipal acute beds (KAD).

In the interviews, informants highlighted that financial risk and residual costs are often borne by the host municipality. Several emphasised that it can be challenging to establish financing models that are both aligned with local organisational arrangements and ensure a fair allocation of costs.

Implications of the models for resource use in the health services

Most unit managers and chief municipal medical officers who responded to the survey consider that the services contribute to improved overall resource use in the health system. They highlighted, among other things, reduced need for travel, better utilisation of local expertise and relief of specialist health services. At the same time, some chief municipal medical officers pointed out that there is potential for improvement with regard to efficient use of resources. The benefits depend on how the services are organised and financed, as well as on stable conditions over time. Where services are undergoing restructuring, or where municipalities have limited control over staffing and capacity, greater uncertainty is expressed regarding future resource use.

Patient satisfaction and perceived safety

Both unit managers and chief municipal medical officers in the host municipalities describe patients as generally satisfied with the services. All respondents in both surveys reported that patients are satisfied to a large or very large extent.

Interviews highlighted reduced travel distance as an important advantage, particularly for frail older people, working patients and patients with chronic conditions. Some managers noted that co-location facilitates closer local collaboration and more coordinated care pathways. The presence of high medical competence and preparedness in the local community was also emphasised as contributing to patient safety. One physician noted that unclear allocation of responsibility at admission and longer time to hospital for some patients may represent disadvantages.

Models in transition

Over the past year, several changes have taken place. From 2026, collaboration on intermediate care beds/shared beds was discontinued at Steinkjer DMS and Stjørdal DMS, while specialist outpatient clinics and day treatment services are being strengthened. From March 2026, the University Hospital of North Norway (UNN) chose to discontinue its partial financing of cottage hospital beds in Nord-Troms. At Sunnfjord Medical Centre, there are plans to close the dermatology outpatient clinic. Following the closure, the centre will no longer provide somatic specialist health services, with the exception of blood bank operations and ambulance services.

At the same time, there are also examples of developments in the opposite direction. At Fosen DMS, for example, St. Olavs Hospital has recently expanded the dialysis service. At DMS Sør-Helgeland, there are plans to expand the service offerings, and work is under way on an assessment of how the inpatient ward should be organised from a clinical, administrative and financial perspective.

There are also ongoing projects involving substantial further development or the establishment of new units. One example is in Gran municipality, where a local medical centre is being constructed and will be co-located with a nursing home and supported housing. The centre is intended to provide health services delivered by Innlandet Hospital Trust as well as intermunicipal services for the municipalities of Gran and Lunner. In Kristiansund, Møre og Romsdal Regional Health Authority,

Kristiansund municipality and the Nordmøre Intermunicipal Political Council are collaborating on the development of a DMC in Kristiansund, offering both specialist health services from the regional health authority and municipal health and care services.