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Health Systems in Transition

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Norway

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Preface

The Health Systems in Transition profiles are country-based reports that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each profile is produced by country experts in collaboration with the Observatory's research directors and staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a profile.

Health Systems in Transition profiles seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries.

Compiling the profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the WHO Regional Office for Europe Health for All database, national

statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) health data, the International Monetary Fund (IMF), the World Bank, and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

A standardized profile has certain disadvantages because the financing and delivery of health care differs across countries. However, it also offers advantages, because it raises similar issues and questions. The Health Systems in Transition profiles can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals. Comments and suggestions for the further development and improvement of the Health Systems in Transition series are most welcome and can be sent to: info@obs.euro.who.int.

Health Systems in Transition profiles and Health Systems in Transition summaries are available on the Observatory's web site at www.euro.who.int/observatory. A glossary of terms used in the profiles can be found at the following web page: www.euro.who.int/observatory/Glossary/Toppage.

The data used in this report reflect information available at 1 January 2006. However, for updated and specific statistics, readers should contact Statistics Norway (www.ssb.no).

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The current series of Health Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Systems and Policies. The European Observatory on Health Systems and Policies is a partnership between the World Health Organization (WHO) Regional Office for Europe, the governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, CRP-Santé Luxembourg, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

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The data used in this report reflect information available at 1 January 2006. However, for updated and specific statistics, readers should contact Statistics Norway (www.ssb.no). Do not hesitate to contact the author regarding this HIT report.

List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CAM	Complementary and Alternative Medicine
CMHC	Community Mental Health Centres
CT	Computer tomography
DRG	Diagnosis Related Group
EEA	European Economic Area
EPR	Electronic Patients' records
EU	European Union
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
GNP	Gross National Product
GP	General Practitioner
HIV	Human immunodeficiency virus
HTA	Health Technology Assessment
HVPU	Reform on downsizing institutions for people with disabilities
ICT	Information and communication technology
KS	Norwegian Association of Local and Regional Authorities
MMR	Measles, mumps and rubella virus vaccine
MRI	Magnetic Resonance Imaging
MSIS	The Norwegian Surveillance System for Communicable Diseases
NATO	North Atlantic Treaty Organization
NAVO	State Negotiation Body
NGO	Nongovernmental Organization
NIS	National Insurance Scheme
NKr	Norwegian Krone
NOU	Royal Commission
NPR	Norwegian Patient Register
OECD	Organisation for Economic Co-operation and Development
PET	Positron Emission Technology
UN	United Nations
US	United States
VAT	Value Added Tax
WHO	World Health Organization
WTO	World Trade Organization

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Executive summary

Norway is a monarchy with a parliamentary form of government. There are three independent government levels – the national government, the county councils and the municipalities. The Norwegian population reached 4.6 million in 2005. The life expectancy in Norway is among the highest in the world. Diseases of the circulatory system are the primary cause of mortality, with cancer being the second largest cause of death.

The Norwegian health care system is organized on three levels, i.e. national, regional and local levels. Overall responsibility for the health care sector rests at the national level, with the Ministry of Health and Care Services. The regional level is represented by five regional health authorities, which have responsibility for specialist health care; and the local level represented by 434 municipalities has responsibility for primary health care (including nursing care).

The parliament's most important functions are: to pass new laws and amend or repeal the existing ones, to adopt the fiscal budget, i.e. to fix the annual revenues (taxes, charges, etc.) and the expenditures of the state, to authorize plans and guidelines for the activities of the state through the discussion of political issues of more general character, to take a stand on plans for reform, to approve major projects and so forth.

In 2003, Norwegian health care expenditure was 10,3% of GDP. Health care expenditure expressed in US\$ PPP per capita was 3572 in 2003, which was much higher than the EU average of 2326 (i.e., among those countries that were members of the EU before May 2004). The Norwegian health care system is primarily funded through taxes. The municipalities have the right to levy proportional income taxes on their respective populations, while the regional health authorities must rely on transfers from the central government. Block grants provide the primary source of funding, but the financing of health care services is also supplemented by state grants, earmarked means and some

user charges. The social insurance system, managed by the National Insurance Scheme (NIS), provides financial security in the case of sickness and disability. There is no exact definition of the “coverage package” in the Norwegian health care system.

The aim of primary care is to improve the general health of the population and to treat diseases and deal with health problems that do not require hospitalization. Each municipality has to decide how best to serve its population with primary care. Primary care is mainly publicly provided. Much of the spending in the municipalities is directed towards nursing, somatic¹ health care and mental health care. Regular general practitioners (GPs) are in practice self-employed, but financed by the NIS, the municipalities and by the patient’s out-of-pocket payments.

The regional level provides the basis for specialist health care. The regional health authorities plan the development and organization of specialist health care according to the needs of the regional population and services are provided by the regional health authorities’ health enterprises. Their planning responsibility also includes health services supplied by other providers, such as private agencies. Tertiary-level specialized health care is delivered in accordance with regulations set out by central government.

With regard to the training of physicians, the number of medical students is limited, and every year approximately 500 students join medical training programmes in Norway. Further education and specialization of physicians is limited. Medical education is financed by the central government. The training of other health care personnel is normally regulated in the same way.

Resource allocation does not vary among the regional health authorities and the municipalities. The regional health authorities are financed by basic grants, earmarked means and activity-based funding (based on the DRG system and other fee-for-service for somatic care from the state). The municipalities’ health care services and nursing care are financed by basic grants, earmarked means, fee-for-service, and local taxes. The authorities have the freedom to set up their own financing arrangements (except for user charges, which are set by the central government), but in practice the same financing arrangements exist throughout the country. The majority of health care providers are publicly owned and, therefore, health care personnel are mainly salaried employees, with the exception of GPs.

The main purpose of the Municipalities Health Services Act (1982) was to improve the coordination of the health and social services at local level, to strengthen those services in relation to institutional care and preventive care, and

¹ Somatic health care is used in this report to mean “general health care”.

to pave the way for better allocation of health care personnel. The act provides the municipalities with a tool to deliver comprehensive health services in a coordinated way. In 1988 the Municipalities Health Services Act was further expanded and county nursing homes were transferred to the municipalities.

The Regular General Practitioners scheme implemented in 2001 is based on a registration system whereby patients can sign onto the list of the GP of their choice. Basic principles of the scheme include patients' freedom to choose whether or not to participate in the scheme, the right to choose another physician as their GP (twice a year) and the right to a second opinion from another general practitioner. The aim of the reform was to improve the quality of the local medical services, to improve continuity of care and ensure a more personal patient–physician relationship. This reform also provided a new model for employing GPs, based on contracted physicians in private practice where capitation, fee-for-service and out-of-pocket payments form the income of GPs.

In 1997, Norway introduced activity-based funding (Innsatsstyrt finansiering, ISF) based on the DRG system for somatic inpatient activity. This measure was further expanded in 1999 to include day surgery. Introduction of activity-based funding has been followed by a substantial increase in the number of cases treated and a reduction in waiting times. The reimbursement of a DRG point is consistent throughout the country. But the regional health authorities are allowed to change these reimbursement rates to their health enterprises.

The hospital reform of 2002 aimed to increase efficiency and consisted of three main strategies: the ownership of the hospitals was transferred from the counties to the central government sector; hospitals were organized as enterprises; and the day-to-day running of the enterprises became the responsibility of the general manager and the executive board. Preliminary results, following these reforms, point to some positive outcomes, such as decreased waiting lists and improved management skills.

In 2001 a new law was passed allowing greater freedom in the establishment of pharmacies. This led to a vertical integration of pharmacy chains owned by wholesale companies and allowed pharmacists to substitute the physicians' prescriptions with another (e.g. generic) brand.

Patients' rights have been strengthened with the passing of the Patients' Rights Act in 1999. Its main purpose was to ensure equality of access to good quality health care.

The Norwegian health care sector has undergone several important reforms during recent decades. Generally, national reforms that have had an impact on the health care system have focused on three broad areas: the responsibility for providing health care services, priorities and patients' rights and cost

containment. Future challenges include further cost containment, integration of care and health inequalities.

The health status of the Norwegian population is one of the best in the world. The key strengths of the Norwegian health care system include provision of health care services for all based on need (regardless of personal income), local and regional accountability, public commitment and political interest in improving the health care system.

1 Introduction

1.1 Overview of the health system

The organizational structure of the Norwegian health care system is built on the principle of equal access to services: all inhabitants should have the same opportunities to access health services, regardless of social or economic status and geographic location. To fulfil this aim, the organizational structure has three levels that mirror political tiers: the national/state level, the five health regions and the municipalities (Fig. 1.1). While the role of the state is to determine national health policy, to prepare and oversee legislation and to allocate funds, the main responsibility for the provision of health care services lies with the five health regions for specialist health care and the 431 municipalities for primary health care (which includes nursing care), and dental care at the 19 counties. At the national level, the parliament (Stortinget) serves as the political decision-making body. Overall responsibility for the health care sector rests at the national level, with the Ministry of Health and Care Services.

1.2 Geography and sociodemography

Norway is located in northern Europe, bordering the North Sea and the North Atlantic Ocean, sharing physical borders with Sweden, Finland and Russia (Fig. 1.2). Its 4.6 million inhabitants live in a total land area of 386 958 km², which averages 15 persons per km². This makes Norway one of the most sparsely populated countries in Europe. The terrain is mostly barren, with high plateaux and rugged mountains broken by fertile valleys, small, scattered

Fig. 1.1 Overview chart on health system

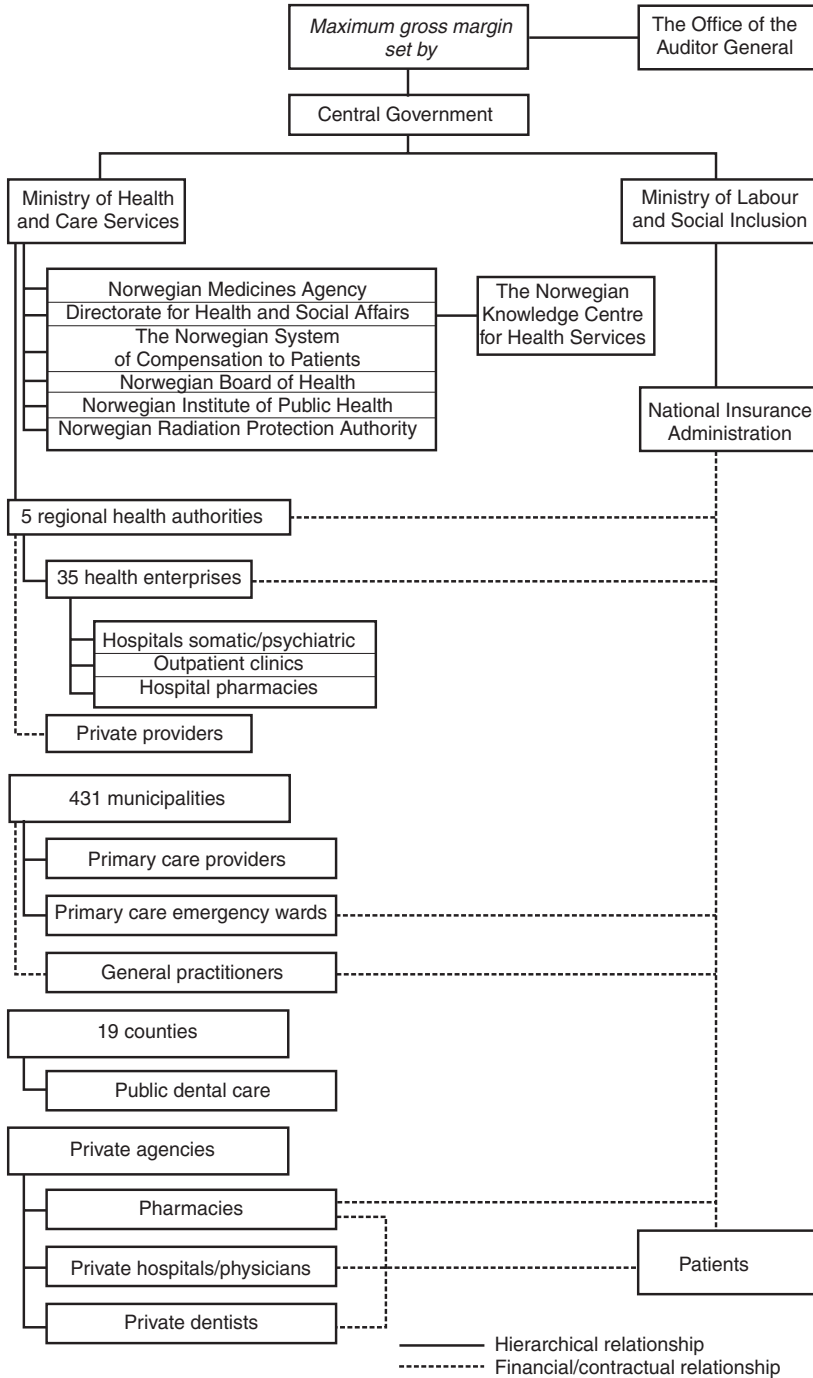


Fig. 1.2 Map of Norway



Source: CIA World Fact Book.

plains, a coastline that is deeply indented by fjords, and arctic tundra to the north. When calculated against the proportion of arable land, Norway has 22 persons per km² of land available for cultivation, compared with eight in both France and Denmark. The climate is temperate along the coast, modified by the North Atlantic current; it is colder towards the interior.

The population of Norway passed 4.6 million in 2005 – an increase of 1.25 million since 1950. In the immediate post-war years the annual growth in the population was approximately 1%. The natural population growth rate, which had steadily decreased since the start of the 1970s to less than 2 per 1000 in the mid-1980s, turned upwards again, reaching an average of 3.4 per 1000 in the

period 1996–2000 – a figure well above average European Union (EU) levels. The population in Norway continued to grow throughout the 1990s. The three reasons for this are immigration, rising birth rates and prolonged life expectancy. With a net immigration figure of 2.1 per 1000 population in 2002, Norway ranks highest among the Nordic countries, closely followed by Denmark.

At the beginning of 2004 the immigrant population in Norway was 349 000 and accounted for 7.6% of the total population. The majority originate from Asia (40%), followed by people from eastern Europe (16%), the Nordic countries (15%), Africa (12%) and western Europe (10%).

The old-age dependency ratio (those aged 65+/20–64) for Norway was 25.7 in 2000, and it is expected to increase to 42.9 by 2040. These figures are below the OECD average of 46 for the year 2040 and also below the other Nordic countries, with the exception of Iceland.

Norway is highly rated with respect to gender equality. Within education, the labour market and political life, Norway is among those countries in which women do very well compared to men. In two of the United Nations indices for gender equality, based on the Gender-related Development Index (GDI) and Gender Empowerment Measure (GEM), Norway was ranked as the most gender-equal nation in 2001 (UNDP 2001; UNECE 2000).

In 2001, the proportion of the population with a university education, among the 30 to 39-year-olds, was 29% for men and 36% for women. In all, 57% of the population over the age of 16 had completed secondary education. In total, therefore, the enrolment level in secondary and tertiary education amounts to more than two-thirds of Norwegians over 16 years, which makes Norway one of the most highly educated countries in the world.

1.3 Economic context

The Norwegian economy is generally characterized as a mixed economy – a capitalist market economy with a clear component of state influence. As in the rest of Western Europe, private property rights and the private sector have largely governed the expansion of most industries. Nevertheless, some industrial activities are owned or even managed by the state. State ownership and the regulation of the private sector characterize Norway as a mixture of market and planned economy.

In 2002 the gross domestic product (GDP) was more than Nkr 1500 billion (1 € was equal to Nkr 8.0073 in 2005). This comprised a total of 44% on household consumption expenditures, 22% on general government

Table 1.1. Population/demographic indicators, 1970–2004, selected years

Indicators	1970	1980	1990	1995	2000	2001	2002	2003	2004
Population (mid-year, thousands)	3 877	4 086	4 241	4 359	4 470	4 514	4 538	4 565	4 591 ^a
Population, female % of total	50.3	50.4	50.6	50.6	50.5	50.4	50.4	50.4	50.4 ^a
% population <15 years	24.5	22.2	18.9	19.5	20.1	20.0	20.0	20.8	21.1 ^a
% population 65+ years	12.9	14.8	16.3	15.9	15.2	15.0	14.9	14.7	14.8 ^a
Population growth %	–	0.32	0.34	0.52	0.18	0.98	0.54	0.62	0.55 ^a
Urban population %	65.0	71.0	75.0	73.0	74.5	75.0	77.6	77.2	77.3 ^a
Population density (population/ km ²)	–	–	13.2	13.5	13.8	13.9	14.0	14.1	14.2 ^a
Fertility rate – total births per woman	–	1.7	1.8	1.9	1.9	1.8	1.8	1.8	1.8 ^a
Crude death rate/ 1000 population	10.0	10.1	10.9	10.4	9.9	9.7	9.8	9.3	9.0 ^a
Live births/ 1000 population	16.7	12.5	14.4	13.8	13.3	12.6	12.2	12.4	12.4 ^a

Source: European Health for All database, January 2006; ^a Statistics Norway, January 2006.

consumption, with 19% being invested (Table 1.2.). The remaining 15% represented the export surplus, indicating that the value of what is produced is higher than what Norway consumes and uses for investment.

GDP in 1970 totalled NKr 23 500 per capita. In 2002, this figure had risen to NKr 337 400. GDP in 1970 calculated at 2002 prices amounts to NKr 128 700. Thus the real growth was approximately 160%, i.e. an annual growth of 3%.

Norway has gradually become one of the richest countries in the world. In comparison with other European countries, its GDP is 43% above the average in the EU (allowing for price differences in the different countries). However, consumption expenditure for Norwegian households is around the average for the 15 countries that belonged to the EU before May 2004. Regarding personal consumption (which includes general government consumption expenditure on the individual, e.g. health and education services), Norway is somewhat above the average.

During the last 50 years, Norwegian businesses and industries have seen some dramatic structural changes. Generally speaking there has been a move from primary (agriculture) and secondary (manufacturing) industries towards tertiary (service) industries. The role of agriculture and manufacturing has diminished while that of services has increased. Primary industries now employ only 4% of the labour force and secondary industries around 22%, while the

tertiary industries account for a total of 75%. The picture is slightly different if one looks at the significance of these industries in the light of their contribution to GDP. Primary industries contribute 2%, secondary industries close to 40% (with petroleum contributing far more in economic value than in employment) and the tertiary industries 59%.

The post-war era has been characterized as a period of rebuilding and reconstruction, with the result that imports exceeded exports for a considerable period of time. Only when oil exports began at the end of the 1970s did Norway gradually build up an export surplus. Norway has had a surplus in external trade in commodities since then, apart from the years 1986–1988. In 2002, the surplus was in the region of Nkr 200 billion.

Approximately three-quarters of Norwegian exports are to European Union (EU) countries and two-thirds of the imports come from these countries. Twelve per cent of imports are from developing countries. As regards exports, oil (and increasingly gas) dominates, followed by metals (especially aluminium) and fish. For imports, motor vehicles (cars and buses) and other means of transport (aeroplanes and shipping vessels) are the most important.

In 1990 the Norwegian Petroleum Fund² was established, and from then on the surplus on the state budget from the oil industry was transferred to a fund outside the domestic economy. In 2005, the market value of the Petroleum Fund's assets was more than Nkr 1000 billion.

1.4 Political context

Norway has been a constitutional state since 1814, following approval of the first democratic constitution and the establishment of the Norwegian Parliament. Almost a century later, in 1905, the country dissolved the union with Sweden and became a sovereign state.

Norway is governed by a three-tier parliamentary system, with each tier governed by a popularly elected body: the national parliament (Stortinget), the county councils and the municipal councils. The parliament has 169 members, and is elected by proportional representation for a four-year period. The King is formally the highest executive authority, although in practice the cabinet – comprising the prime minister (chosen by the King) and his/her cabinet members (selected by the prime minister) – has the executive power.

² The Norwegian name as of 1 January 2006 is Statens pensjonsfond – Utlandet.

Table 1.2 Macro-economic indicators, 1990–2004, selected years

Indicators	1990	1995	1997	1999	2000	2001	2002	2003	2004
GDP in billion ^a NKr	727	937	1 111	1 233	1 469	1 527	1 521	1 562	1 717 ^a
GDP growth rate (%)	2.1	4.4	5.2	2.1	2.8	1.9	1.3	2.9	3.1 ^a
GDP per capita in 1000 NKr	171.4	215.1	252.3	276.3	327.1	338.1	334.8	345.4	373.9 ^a
GDP per capita US\$ PPP	17 658	23 524	27 982	29 887	36 242	36 474	38 050	–	38 765 ^a
GDP PPP Total billions US\$	74.9	102.5	123.3	133.4	162.8	164.6	–	–	178.0 ^a
GDP in billion NKr	705	925	1 100	1 218	1 455	1 515	1 523	1 590	1 724 ^a
Value added agriculture and fishery (% of GDP)	3.4	3.0	2.4	2.4	2.1	2.0	1.8	1.5	1.5 ^a
Value added industry (% of GDP)	33.9	34.1	37.1	34.6	41.8	39.5	37.2	37.4 ^a	39.2 ^a
Value added services (% of GDP)	62.7	62.9	60.5	63.1	56.1	58.5	61.0	61.1 ^a	59.2 ^a
Annual average rate of inflation in %	4.1	2.4	2.6	2.3	3.1	3.0	1.3	2.5	0.4 ^a
Labour force 1000	2 142	–	2 287	2 333	2 350	2 361	2 378	2 375	2 382 ^a
Unemployment, % total population	5.3	5.0	4.1	3.2	3.4	3.5	3.9	4.5	4.5 ^a
Employment rate, % of active population	65.6	–	69.6	71.0	70.9	70.9	70.7	69.6 ^a	69.3 ^a
Real interest rate	10.6	5.2	3.4	5.3	5.8	5.7	7.4	2.2	–
Official exchange rate NKr/US\$	6.2544	6.3369	7.0788	7.8047	8.8058	8.9879	7.9702	7.0824	6.74 ^a
Short-term debt outstanding current US\$)	4 894	6 376	4 828	4 244	3 419	4 020	7 185	–	–
Overall budget balance, including grants (% GDP)	2.2	3.4	7.8	6.1	15.0	13.7	9.2	–	–
Gini coefficient	0.228	n/a	n/a	0.254	0.275	0.243	–	–	–

Source: Statistics Norway and Ministry of Finance, 2005; ^a Statistics Norway, 2006.

Note: ^a billion = 1 000 million.

Parliamentary members must leave the parliament if they are chosen to serve in the government.

In 2003, there were 19 counties and 431 municipalities. The capital, and the largest city, Oslo, is formally both a municipality and a county. Population density varies widely throughout Norway, ranging from 218 to 500 000 inhabitants per municipality. There are some 20 municipalities with fewer than 1000 inhabitants, and one-third have between 2000 and 5000 inhabitants.

The municipalities are responsible for health promotion, primary health care, care of the elderly, care of people with disabilities, including mental disabilities, kindergarten and primary school education, social work (child protection and social protection), water, local culture, local planning and infrastructure. The counties are responsible for dental care, secondary education, energy delivery and communication. The state level, delegated to five regional health authorities, is responsible for secondary care.

Politically, the country has been stable, with a Labour Party (Arbeiderpartiet) holding office between 1945 and 1965. From 1965 to the time of writing, Norway has had a Labour government, alternating with periods of non-socialist coalition governments. From 2001 to 2005, the country was ruled by a three-party coalition government (Christian Democratic Party (Kristelig Folkeparti), Liberal Party (Venstre) and Conservative Party (Høyre)). A new government coalition came to power following the 2005 election with the Labour Party for the first time ever in a government coalition, with the Socialist Left Party of Norway (Sosialistisk Venstreparti) and the Centre Party (Senterpartiet).

Traditionally, close cooperation with the other Nordic countries: Denmark, Sweden, Finland and Iceland, has been the norm, and there is a social security convention among the Nordic countries. In 1972 and 1994, a referendum was held on whether or not Norway should join the European Union. Both times this proposition was turned down. Norway has ratified several bilateral social security agreements with other Nordic countries, as well as the European Economic Area (EEA) Agreement, which came into force in 1994.

Norway is a member of the United Nations, WTO, NATO, Council of Europe and Council of the British Isles. Norway has signed among others the following international treaties and documents: GATS, Convention on the Rights of the Child, European Convention on Human Rights, International Bill of Rights, the Barents Health Programme.

1.5 Health status

The health of Norwegians improved considerably during the twentieth century and especially during the last decades. In 2004, life expectancy at birth was 77.5 years for males and 82.3 years for females (Table 1.3). This is a significant increase from the period 1946–1950 when the average figures were 69.3 years for males and 72.7 years for females.

One of the major reasons for increased life expectancy in Norway since the 1970s is attributed to decline in mortality from diseases of circulatory system (Table 1.4). Such diseases still account for one third of all standard death rates (SDR) in Norway while malignant neoplasms are the second largest cause of mortality. SDR from malignant neoplasm has not changed during the last thirty years and in 2003 was 170.4 per 100 000 inhabitants. Mortality from trachea/bronchial/lung cancer has doubled: from 15.5 per 100 000 inhabitants in 1970 to 34.1 per 100 000 inhabitants in 2003. Similar trends occur with regard to mortality from mental disorders and diseases of nervous system, where the mortality rate has increased twofold during the last 30 years.

As in all western countries, infectious diseases have been on the decline due to better hygiene, vaccinations and much-improved living standards. The HIV epidemic hit Norway in the 1980s, but effective measures have been introduced, and the total number of persons infected each year is well under 100. In the period from 1984 to 2005, 3263 persons were registered as HIV positive in Norway, whereas 833 were diagnosed with AIDS. In accordance with the Norwegian Communicable Disease Act, all counselling and treatment is free of charge for everybody who is infected.

The post-war baby boom, which lasted until the mid-1960s, was followed by a decline in the birth rate, reaching its lowest point around 1985. In 2005 the total fertility rate was 1.84. Since the beginning of the 1970s, the average childbearing age has increased by approximately four years, and the average age for first-time birth is 28.1. During the last three decades teenage pregnancy has declined significantly: in the 1970s teenage births accounted for 20% of those giving birth for the first time, whereas in 2005 the figure was less than 5%.

Abortion rates rose sharply at the beginning of the 1970s. Since the introduction of the Abortion Act in 1978, numbers have stabilized at between 14 000 and 16 000 per year. In 2005, 13 989 abortions were carried out, a figure equivalent to some 25% of all live births. The number of abortions among teenagers in Norway in 2005 was about 2200, while in 2001 it was 2600. The perinatal death rate is one of the lowest in the world and decreased from 14.2 per 1000 births in 1975 to 5.2 in 2004.

Absences from work due to sickness amount to almost 7% of the total number of working days. One per cent of those is short term and self-certified, whereas 6% are certified by a physician (women have a slightly higher percentage absence rate due to sickness than men, especially when it comes to physician-certified absences).

The percentage of regular daily smokers in Norway has decreased slightly, from 31% in 1980 to 26% in 2004 (Table 1.5). The standardized mortality rate due to smoking-related causes has also been decreasing since the 1990s. The proportion of overweight and obese members of the population was 35% and 8% respectively in 2004, while in 1995 overweight and obese inhabitants totalled 27% and 5%, respectively.

Indicators show significant improvement in dental health in Norway during the last three decades, particularly among children. In 2004, the number of decayed, missing or filled teeth was 1.3 among 12-year-olds in comparison with 8.4 in 1975 (Table 1.6).

Table 1.3 Mortality and health indicators, 1970–2004, selected years

	1970	1980	1990	1995	1997	2000	2001	2003	2004
Life expectancy at birth, female (years)	77.5	79.4	80.0	81.0	81.2	81.6	81.7	82.2	82.3 ^a
Life expectancy at birth, male (years)	71.1	72.5	73.5	74.9	75.5	76.1	76.3	77.2	77.5 ^a
Life expectancy at birth, total (years)	74.2	75.8	76.7	77.9	78.4	78.8	79.1	79.7	79.9 ^a
Crude death rate per 1000 population, female	8.9	9.1	10.3	10.5	10.4	9.9	9.8	9.5	9.2 ^a
Crude death rate per 1000 population, male	11.1	11.2	11.4	10.7	10.2	9.8	9.7	9.1	8.8 ^a
Infant deaths per 1000 live births	12.8	8.05	7.02	4.13	4.2	3.8	4.1	3.5	3.2 ^a

Source: European Health for All database, January 2006; ^a Statistics Norway, 2006.

Table 1.4 Main causes of death per 100 000, 1970–2003, selected years

	1970	1980	1990	1995	1997	2000	2001	2003
SDR, all ages per 100 000								
– all causes	925.6	820.9	774.1	712.8	684.4	652.2	642.2	608.2
– diseases of the circulatory system	460.9	388.03	344.8	295.5	275.5	245.5	237.5	214.5
– cerebrovascular diseases	143.1	97.7	84.4	69.8	67.5	57.9	54.7	50.2
– malignant neoplasms	171.4	174.1	179.1	180.1	184.3	175.2	174.3	170.4
– trachea/bronchial lung cancer	15.5	20.6	28.1	31.0	33.5	32.8	33.3	34.1
– diseases of the respiratory system	86.5	68.2	70.02	69.4	54.9	58.2	56.2	50.9
– diseases of the digestive system	21.3	24.3	22.8	19.99	21.3	21.2	19.5	19.1
– diabetes	7.26	8.23	8.27	8.13	11.12	9.46	10.33	9.9
– external causes	60.04	60.6	54.2	42.9	42.5	42.7	40.1	43.8
– suicide and self-inflicted injury	8.88	12.7	15.1	12.2	11.8	11.9	11.9	10.8
– mental disorder and disease of nervous system	14.9	18.2	29.0	30.8	33.99	36.4	39.96	35.1
– infectious and parasitic disease	7.44	6.36	5.31	6.34	6.78	7.71	7.31	8.21
– tuberculosis	–	–	1.23	1.05	0.98	0.71	0.77	0.65

Source: European Health for All database, January 2006.

Table 1.5 Factors affecting health status, 1980–2004, selected years

	1980	1990	1995	2000	2001	2003	2004
% of regular daily smokers in the population, age 15+	31	35	33	31	30	26	26 ^a
SDR, selected smoking related causes of death, per 100 000	–	325.39	279.92	237.97	229.39	212.09	–
Pure alcohol consumed, litres per capita, age 15+	4.84	4.39	4.20	4.74	4.68	4.82	6.22 ^a
SDR, selected alcohol related causes of death, per 100 000	–	89.33	71.07	55.24	51.77	52.83	–
Overweight population % total pop. 25<BMI<30 ^b	–	–	27.3	–	–	35.0 ^a	–
Obese population % total pop. BMI>30 ^a	–	–	5.0	–	–	8.0 ^a	–

Source: European Health for All database, January 2006; ^a Statistics Norway, 2006; ^b Organisation for Economic Co-operation and Development, 2004.

Table 1.6. Decayed, missing or filled teeth at age 12 years, 1975–2004, selected years.

	1975	1980	1990	1995	2000	2001	2002	2003	2004
DMFT	8.4	8.4	2.7	1.9	1.5	1.0 ^a	1.1 ^a	1.3 ^a	1.3 ^a

Source: European HFA Database, ^a Statistics Norway, January 2006.

2 Organizational structure

2.1 Historical background

The expansion and development of the Norwegian health care system must be viewed alongside the country's general standard of living and economic growth.

The fact that the country remained poor and that the majority of the population lived in rural sparsely populated areas was reflected in the health care system well into the twentieth century. The first significant number of physicians established themselves during the second part of the eighteenth century; and it was not until the middle part of the nineteenth that the population–physician ratio passed 5000:1. At the same time the development of hospital-like institutions took place, but physicians and medical personnel were still rare in rural areas. In the early days of the health care system the municipalities and volunteer organizations played an important role as welfare and health care providers. In preventive public health, for example, the role of the state was to employ physicians as public ‘officers’, and from 1836 and onwards, they were known as district medical officers. From about the middle of the nineteenth century, some municipalities also hired physicians who were responsible for the care of the sick poor.

The beginning of the twentieth century was marked by an increase in public responsibility for health matters at both state and municipal levels. Health care institutions were built to provide care and treatment for the sick and poor as well for the general population. As the population grew and industrialization increased, hospitals were built, especially in urban areas. These were owned and run either by voluntary organizations, municipalities or the state. Health care insurance schemes developed, based on individual applications. The Practitioners’ Act of 1912 provided for everyone to have equal access to physicians’ services regardless of their income and settlement.

After the Second World War, the state governmental structure for health care changed significantly when the Directorate for Health (Helsedirektoratet) was established as part of the Ministry of Social Affairs³ (Sosialdepartementet). This directorate was a regulatory instrument of the medical profession, and gave physicians a unique role as policy and professional practitioners. Undoubtedly, the directorate's work and the health policy were inspired by the United Kingdom Beveridge Report.

One important step towards universal coverage for welfare services and expenses was the introduction of the National Insurance Scheme (NIS) in 1967. The NIS is a public universal insurance scheme that assures everybody a minimum of social security, regardless of income, and is administrated by the National Insurance Administration (Trygdeetaten).

After the Second World War the role of the hospitals widened, with increasing provision in specialized services. There was also a growth in ambulatory care services. The three-tier structure for hospitals was developed and consisted of central, regional and specialist hospitals, with the aim of providing a more efficient service. The Hospital Act of 1969 (which came into effect in 1970) introduced a unified system for all medical institutions, making counties responsible for planning, building and managing hospitals in order to meet the needs of their respective populations (the central government gained control of two tertiary level hospitals). Since the adoption of the act, each of Norway's 19 counties assumed responsibility for the financing, planning and provision of specialist health care. An overall fundamental strategy of health services from the regional perspective was also developed during the 1970s. However, the picture changed with the advent of the hospital reform in 2002, when central government took over responsibility for specialist health care. The country was divided in five regional health authorities, and the hospitals were part of the health enterprises.

One of the main difficulties with regard to primary health care was in achieving sufficient cover in physician services as required by the Practitioners Act of 1912. The Municipalities Health Services Act of 1982 (which came into effect in 1984) made local municipalities responsible for all services under primary health care. This marked the end of the district medical officer system that had been established by central government in the middle of the 19th century. This, in turn, was followed by the abolition of the Directorate for Health. The municipalities' responsibilities have been further expanded to

³ Ministries in Norway regularly change name and tasks; currently, the Ministry of Health and Social Services and the Ministry of Labour and Social Inclusion are responsible for most of the tasks of the former Ministry of Social Affairs.

include environmental health services, responsibility for nursing homes (which was shifted from the counties to the municipalities) and responsibility for care of people with mental disabilities (HVPU-reformen). In 2001, the regular general practitioners' scheme was introduced, giving individuals the right to choose one regular GP.

The economic growth of the country was just below the OECD average until the 1970s when Norway discovered vast amount of petroleum resources in the North Sea. Undoubtedly, the oil-propelled economy has carried the country to one of the richest in the world today.

The years following the Second World War can be described as a period of continuous reforms in many sectors, including the health sector, while seeking to achieve an optimum balance between the state and local government. The process of devolving power from central to local government has continued, with the aim of focusing as much as possible on the municipal level. The philosophy behind this is that decentralization is an expression of applied democracy. It brings decision-making closer to those who are affected and promotes public participation in local political affairs. Moreover, it is believed that delegation of authority usually leads to the simplification of administrative procedures. The central authorities are responsible for national policy, for drawing up general guidelines, for advising, and for ensuring that services offered comply with national goals. Maintaining the principle of equal access to public service plays a critical role of the central authorities in a decentralized system.

However, maintaining the principle of equal access to public services while, at the same time, passing responsibility to local/regional authorities is challenging for central government. There are contradictory elements at play. It can therefore be argued that although the central government delegates tasks, it clearly continues to control the health care services through guidelines, legislation, directives, instructions, budgeting, the financing system, supervision and auditing. For instance, while the responsibility for primary health care services including the regular GP scheme is delegated to the municipalities, all GPs' source of incomes are, in fact, set by the central government and there are, therefore, no local differences. There are more examples, but this tension between central and local government is not unique to Norway.

2.2 Organizational overview

The central governance of health

The Ministry of Health and Care Services (Helse- omsorgsdepartementet) outlines national health policy, prepares major reforms and proposals for legislation, monitors their implementation and assists the government in decision-making. The government decides on general national priorities and proposes bills to be discussed by parliament.

The Ministry of Health and Care Services is responsible for administering the following services: primary health care, specialized health care, public health, mental health, medical rehabilitation, dental services, pharmacies and pharmaceuticals, emergency planning and coordination, policies on molecular biology and biotechnology and nutrition and food safety. The Ministry of Education and Research is responsible for planning and partially subsidizing the education of health personnel. The Ministry of Health and Care Services has administrative responsibility for the following subordinate agencies: the Directorate for Health and Social Affairs, the Board of Health, the Institute of Public Health, the Medicines Agency, the Radiation Protection Authority, the Patient Register and the Biotechnology Advisory Board.

The Ministry of Labour and Social Inclusion (Arbeids- og inkluderingsdepartementet) is not directly involved in the health care system but has indirect involvement since its task involves labour and social affairs issues. Sometimes, these boundaries of responsibility are not clear cut. The ministry also has responsibility for the National Insurance Administration, which provides significant financing for the activities of the health system.

The Directorate for Health and Social Affairs (Sosial- og Helsedirektoratet) is a professional body within the field of health and social affairs and has legal authority within this field. The directorate also contributes to the implementation of national health and social policy (for instance, the escalation plan for mental health), and it serves as an advisory body to central authorities, municipalities, regional health authorities and voluntary organizations. An essential task for the directorate is to develop and strengthen preventive work and to widen the availability of services within the field of health and social affairs (for instance non-smoking campaigns). The Patients' Ombudsmen, one in each county, report to the directorate. Formally, subordinate to the Ministry of Health and Care Services, the directorate also services the Ministry of Labour and Social Inclusion.

The Knowledge Centre for Health Services (Nasjonalt kunnskapssenter for helsetjenesten) is a relatively new public agency (set up on 1 January 2004) that

is autonomous and independent, but subordinate to the Directorate for Health and Social Affairs with regard to the setting of overall goals and tasks. The main responsibilities of the centre are to provide decision-makers and health personnel with synthesized research evidence on the effects of health interventions and quality of the health services. The centre has neither the authority to develop, nor the responsibility to implement health policies.

The Norwegian Board of Health (Statens Helsetilsyn) is a national supervisory authority with responsibility for the general supervision of health and social services. The board oversees the population's need for health and social services, and ensures that services are run in accordance with professional standards. The board also collaborates in preventing failures and mistakes within the health care system. Locally, supervision is carried out by the Governmental Regional Board (in the counties). With regard to health and social affairs, the regional boards report to the Board of Health.

The Norwegian Medicines Agency (Statens legemiddelverk) is a national, regulatory authority for new and existing medicines and the supply chain. The agency is responsible for supervising the production, trials and marketing of medicines. It approves medicines and monitors their use, ensures cost-efficient, effective and well-documented use of medicines, and regulates prices and trade conditions for pharmacies.

The Norwegian Radiation Protection Authority (Statens Strålevern) is the competent national authority agency in the area of radiation protection and nuclear safety in Norway. The agency is responsible for overseeing the use of radioactive substances and fissile material; coordinating contingency plans against nuclear accidents and radioactive fallout; monitoring natural and artificial radiation in the environment and in the workplace, and increasing knowledge about the occurrence, risk and effects of radiation. The Radiation Protection Authority is organized under the Ministry of Health and Care Services. It provides assistance to all ministries on matters dealing with radiation, radiation protection and nuclear safety.

The Norwegian Patient Register (Norsk pasientregister, NPR) was founded in 1997. The Ministry of Health and Care Services owns the register. The NPR collects and verifies patient data from all public somatic hospitals and psychiatric institutions in Norway, as well as from some private hospitals. The register includes data on all hospitalizations at somatic hospitals (24-hour hospitalizations and outpatients).

The National Institute of Public Health (Nasjonalt folkehelseinstitutt) is a national centre for health monitoring and for expert knowledge of epidemiology, infectious disease control, environmental medicine, forensic toxicology and drug abuse. It is also a research institution with comprehensive national and

international cooperation. The Norwegian Institute of Public Health was established in 2002. The institute resulted from the merger of the National Institute of Public Health, National Health Screening Service, the Medical Birth Registry in Bergen and the Department of Drug Consumption Statistics and Methodology from the Norwegian Medicinal Depot. The staff have also been supplemented with employees from the Norwegian Board of Health and the Ministry of Social Affairs and Health.

The Norwegian System of Compensation to Patients (Norsk Pasient-skadeerstatning, NPE) has covered and handled patient injury compensation on behalf of hospital owners and municipal authorities since 1988. The NPE has by definition a neutral role and, as a rule, only covers the expenses of the attorney when a case is presented to the Patients' Injury Compensation Board. The decisions made by NPE are binding on the hospital authorities and municipalities, but a complainant can appeal to the Patients' Injury Compensation Board. Formally, the NPE is subordinate to the Ministry of Health and Care Services.

The National Insurance Administration (Trygdeetaten) has the administrative responsibility for the NIS, a public insurance scheme that secures everybody a minimum level of social security. The benefits under the NIS cover life subsistence to benefits for specific expenses. The NIS provides benefits for illness, accidents, bodily defects, pregnancy, birth, unemployment, old age, disability, death, and loss of the breadwinner. In addition, the NIS gives benefits to single breadwinners. The NIS is formally responsible to the Ministry of Labour and Social Inclusion. Compulsorily insured under the National Insurance Scheme are all persons who are either resident or working as employees in Norway or on permanent or movable installations in the Norwegian Continental Shelf. The National Insurance Administration function has an administrative body for financing public health services, for instance partly financing GPs, specialists, pharmaceuticals, ambulatory care, dental care, physiotherapists, psychologists, midwives etc. For further reading, see section 3.2.

The Office of the Auditor General (Riksrevisjonen), established in 1816, is the Norwegian supreme audit institution and the supervisory body of the Norwegian Parliament, and has independent agency status. The main task of the Office of the Auditor General is to monitor public assets and ensure that they are used and administered according to sound financial principles, in keeping with the decisions and intentions of parliament. Since July 2002, the Office of the Auditor General has established a department for health services, thereby widening its remit to include the health care sector, in addition to its original auditing role.

In past years, there have been major changes in organizations at the central level (see section 7.1 for further reading).

Municipalities – primary care

The country's 431 municipalities, whose sizes vary considerably, are responsible for the provision and funding of primary health care and social services. The Municipalities' Health Care Act defines their responsibilities for primary health care services and patients' rights. All citizens have the right of access to health care services in their community.

The municipalities are responsible for primary health care, including both preventive and curative treatment such as:

- Promotion of health and prevention of illness and injuries, including organization and running school health services, health centres, child health care provided by health visitors, midwives and physicians. Health centres offer pregnancy check-ups and provide vaccinations according to the recommended immunization programmes.
- Diagnosis, treatment and rehabilitation. This includes responsibility for general medical treatment (including emergency services), physiotherapy and nursing (including health visitors and midwives).
- Nursing care within and outside institutions. Municipalities are responsible for running nursing homes and home nursing services. The health services outside institutions are, to a varying degree, organized jointly within the same municipal department for treatment and care.

The general practitioners

There are approximately 4000 regular GPs in Norway. The GP acts as gatekeeper and agent for the patient with regard to the provision of health services. At present 99% of the population is registered on the regular GP scheme, a list system, which aims to strengthen the patient–physician relationship by giving the patient the right to choose a regular general practitioner.

The maternal and child centres/school health centres

Public health and preventive measures are important features within the paediatric area. Preventive maternity care and childcare are usually provided at local health centres and municipality schools.

The counties

The hospital reform of 2002 took away the counties' responsibility for specialist health care. At present (2006) their responsibilities include organizing public dental care in cooperation with the municipalities. The counties also have some responsibilities with regard to general public health. In principle, the county politicians have virtually no direct influence on the health care system.

Regional health authorities (de regionale helseforetakene) – specialized health care

Norway's five regional health authorities are responsible for the provision of specialized care. This includes both somatic and mental health institutions, as well as other specialized medical services, such as laboratory, radiology and ambulatory services, special care for persons with drug and alcohol addictions. There are at present 32 health enterprises under the five regional health authorities. The names of each region, together with the number of inhabitants, are as follows:

- Northern Norway Regional Health Authority (Helse-Nord), inhabitants: 462 000
- Central Norway Regional Health Authority (Helse-Midt), inhabitants: 649 000
- Western Norway Regional Health Authority (Helse-Vest), inhabitants: 956 000
- Southern Norway Regional Health Authority (Helse-Sør), inhabitants: 899 000
- Eastern Norway Regional Health Authority (Helse-Øst), inhabitants: 1 671 000.

Private health care sector

The Norwegian health care system includes both private not-for-profit and private profit-making agencies. Private sector services are in most cases fully embedded in the public system, with some exceptions.

Not-for-profit agencies typically include hospitals or institutions set up as trusts that, in principle, are financed and seen as an integrated part of the public health services, i.e. the diaconal trust owned by the Norwegian church.

Private profit-making agencies have a subordinate role within the Norwegian health care system and were established primarily to complement publicly-funded services, for example, plastic surgery. As an illustration of the private

sector's subsidiary role in the health care system, it is worth mentioning that in 2004 there were only 284 private somatic hospital beds, while there were 13 000 hospital beds in the public sector.

In short, private health care providers are situated mainly in urban areas and there are only three areas where they are prominent in health care services provision: namely, substance abuse treatment, rehabilitation and dental care. With regard to nursing care, Statistics Norway revealed that in 2000 approximately 90% of the nursing homes were owned by the municipalities, whereas only 3% were commercially run. Some support services such as radiology and laboratory services, defined as specialist health care services, are dominated by private profit-making providers. Figures from 2003 show that GPs order 60% of the laboratory tests run by private agencies, and 80% of the referrals to private radiology centres. In addition, most of the pharmacy chains are privately owned, whereas around 10% - 15% (measured in volume of sales) of the pharmacies are owned by the public regional health authorities.

2.3 Decentralization and centralization

The health care systems in Scandinavian countries are often characterized as being run according to a decentralized NHS model: funding is raised by taxation and the main players are public (Rice and Smith 2002). In comparison with the centralized British NHS, local and county governments have an important role in allocating resources. It is hoped that through decentralization it will be possible to lessen bureaucracy, improve the management of care and enhance user information. Following hospital reform, the system in Norway changed from a decentralized to semi-centralized NHS model (Hagen and Kaarbøe, 2004). Consequently, the responsibility for primary care and secondary care has been divided between different governmental levels. The regional health authorities are responsible for specialized health care, while the municipalities are responsible for primary health care.

The organization of the regional health authorities and the health enterprises is unique to Norway (Joint Committee Report 2004) (see sections 6.4 and 7.1). The regions have two roles, the authority role and the enterprise role. In their principal role regions have a "care role" ("sørge for rollen") in providing the population with specialized health care services; the other is as a supplier and producer of specialized health care, since regions own the health enterprises. During the last three decades Norway has developed enterprises that enjoy an element of freedom similar to that seen in the private sector, although the state has built-in directing/steering and control mechanisms in the organization, in

other words an “in between solution”. The Norwegian oil company, Statoil, was the forerunner for this model. Health enterprises do not compete in the same sort of market as Statoil and do not make a profit, but rely on funding transfers from central government. These enterprise models, a mix of private and public elements, are unique to Norway. It is difficult to locate this system in the organizational chart, but they can be seen as a delegation of power. This involves shifting the responsibility to local offices or organizations outside the structure of the central government such as quasi-public (nongovernmental) organizations, but with central government retaining (in)direct control in so-called state-owned companies (SOC). Principal health policy objectives and frameworks are determined by central government and form the basis for managing the enterprises. The day-to-day running of the enterprises is, however, clearly the responsibility of the general manager and the executive board. In this way the reform is also about decentralization of the management process.

The municipalities have a great deal of freedom in organizing health services, which is one of the many tasks for which they are responsible. There is no direct command and control line from central authorities down to the municipalities who are responsible for primary health care. The funding system was changed in 1986 giving the municipalities a greater degree of autonomy in the global transfer from the state. The earmarked funding system from the state to the municipalities is considered to be an effective tool to increase resources in certain areas as well as improving quality standards.

Unlike the regional health authorities the municipalities have the right to levy taxes on the population in order to finance their activities. Even though the responsibility for the health services is delegated there is a large element of third-party payment involved (as illustrated in Chapter 3) and legislation is a useful control tool (as illustrated in Chapter 4).

2.4. Patient empowerment⁴

Patients' rights

The rules relating to patients' rights can be divided into three groups:

1. the right to be a patient (e.g. to obtain a diagnosis and to receive treatment)
2. rights as patients (e.g. to be informed, to be given a copy of one's medical records)

⁴ This section is based on Molven (2002).

3. procedural rights (e.g. to be given a second opinion on a matter, to bring a matter to court).

The right to be a patient

Parliament has declared that the population should be provided with health services and health care workers who should provide help according to priorities. It has also stated that when specific criteria are met, people have the right to be patients, and the right to receive health care. Health care services must meet at least minimum standards, and in some cases it must be provided within specified time limits. Those who have the duty to provide health care services cannot refuse to do so on financial grounds or on the grounds of their own priorities. That the legislative authority is able to stipulate this, and has done so in specific terms, is due in no small part to the fact that the country generally has a sound economy, which makes this possible.

The following example illustrates what this means in practice for the municipalities. Section 2-1 of the Municipal Health Services Act and section 2-1 of the Patients' Rights Act state that citizens have a right to "necessary health care". An MS patient who, based on this provision, received 22 hours' home nursing care and home help from the municipality, made a claim for more assistance. The municipality refused, partly for economic reasons, and contended that the municipality had the right to decide what constituted sufficient help. The patient brought the matter to the court. In 1991 the Supreme Court concluded that the help she received in the home did not comply with legal requirements. In her condition the help given did not accord with the law that gave her a guarantee of "necessary health care", and the court stated that she had a right to more help at home. The municipality could not refuse to provide the "necessary health care" because of economic reasons.

For many years now the debate has focused on the extent to which people have the right to receive health services. The claim for general health services from the municipalities has not been much disputed since 1991 when the Supreme Court confirmed this right. However, the question now is whether people can claim the right to specialized health services from the state and if so, to what extent. The Act on Specialized Health Services is not quite clear about this issue.

Rights as patients

People have many explicit rights as patients. These rights are based on the principle of patient autonomy: to a great extent patients are regarded as independent in their dealings with the public health services and health care workers. Patients have the right to: participate in the process of treatment, be

informed, make their own decisions, have access to what is written about them, and be allowed to be with their parents and others (this applies to patients who are children).

According to Molven (2002) objections have been raised about the fact that patients were given many rights, and that these rights are explicitly explained in the Acts. Health workers believe that this makes the patient–provider relationship more bureaucratic (Molven 2002). The patients have been given what we may call procedural rights to put the law into action if the providers themselves do not meet these demands.

Procedural rights

It is regarded as a fundamental right that a patient is able to review decisions made by the public authorities, including public health authorities, especially if he or she believes that a decision has been made which contravenes their rights according to the law. There are two types of procedural rights:

1. the right to have decisions reviewed and reversed
2. the right to demand that health care workers and hospitals are corrected.

Patients who think that their rights to receive health care, or that their rights as patients, have not been met, can ask the supervisory authority to review the decision. This authority is usually the County Medical Officer, who is established in every county. Their main task is to supervise health services on behalf of the state in order to ensure that acts and regulations are followed. The County Medical Officer is independent of those who provide health services.

Patient choice

Patient choice is a complex issue that is frequently the subject of political debates. In practice, choice in the Norwegian health care system is determined by the fact that the NIS is public and monopolistic, to a large degree in public ownership and provides a service. Opting out of public arrangements involves considerable out-of-pocket payments. It is difficult to measure the degree of choice in the health care system, but the government has set up some mechanisms in order to increase that level of choice.

In relation to the regular GP scheme, the patient can request registration with a GP of his or her choice, which can include a GP in another municipality. A person who is registered with one GP has the right to change to another GP no more than twice a year, provided there is free capacity on the requested list. Upon referral from a GP the patient is entitled to a re-evaluation (second opinion) of his or her needs to receive specialist treatment.

The Patients' Rights Act stipulates the patient's right to choose the hospital, but he or she cannot choose the type of treatment (i.e. how specialized that treatment should be in the hospital). In 2004 the Patients' Rights Act was amended to extend the free choice of hospital to include those private hospitals that have entered into an agreement with the regional health authorities.

The patients' entitlement to necessary health care also extends to the right to have that care fulfilled within a specific, individually determined time limit. Patients must be informed of the time limit, and have the right to treatment in a private or foreign hospital if the time limit is exceeded.

Information for patients

A free information service (Internet and telephone) exists to assist patients with their choice of hospitals. This service also offers patients information about the anticipated waiting time for the actual treatment at various institutions, and on the quality of treatment those institutions can offer (based on the national quality indicators). As part of the free hospital choice, there are also established quality measures to decrease the information asymmetry between patient and provider.

In addition, information is provided about the telephone and Internet sites in connection with public health: smoking information centres (røyketelefonen), poison information centres (giftinformasjonen), mental health information centres (mental helsetelefon), substance abuse centres (rustelefonen), etc.

However, regarding the ethnic minorities, it is outlined in NOU 1995:6 that language barriers make it difficult for Sami⁵ people to obtain information on diagnosis, treatment and other health care issues. Similar concerns have been raised with regard to immigrants.

Complaints procedures (mediation, claims)

Norwegian patients' rights are of such a nature that they can give rise to substantive claims from patients (Molven 2002). Patients can take matters to court and compel hospitals and physicians to comply with the law. For example, if a physician does not give a patient a copy of his or her medical records, the court can order the physician to do so.

The County Medical Officers have the authority to reverse decisions regarding health care and the rights of patients that violate the law, and can

⁵ Indigenous people of Sápmi, which encompasses parts of northern Sweden, Norway, Finland and the Kola Peninsula of the Russian Federation.

compel those who provide health care, i.e. health workers and health authorities, to reverse such decisions. Those who provide health care must be prepared to follow the decisions made by the County Medical Officers and the central Norwegian Board of Health.

If patients believe that health care workers or the health services have failed to do their duty, this can also be taken up with the supervision authority, irrespective of whether or not the patient can achieve a result. For example, if the patient believes that he or she has received poor quality health care services, e.g. if they have been injured as a result of negligence, they can ask the supervising authority to investigate the case. The authority can check on the quality of the treatment that the patient has received and can check on the services more generally. There seems to be general agreement that such a control system, which has functioned for many years, contributes both to patients' safety and legal safeguards, and to raising the quality of health services.

According to the Patients' Rights Act, every county must have a Patients' Ombudsman whose purpose is to safeguard patients' rights, interests and legal rights in relation to specialist health care, and improve the quality of the health service. To a reasonable extent, the Patients' Ombudsman can provide information to anyone who requests it, advice and guidance on matters that are included in the remit of his or her work as an ombudsman. The Patients' Ombudsman alone determines whether or not a request provides adequate grounds for investigation. If the ombudsman decides not to handle the case, the person who made the request must be notified, and be given a brief explanation for this decision.

The act gives a patient the right to complain if the rights laid down are not fulfilled by the health service providers, or if the patient feels that he or she has not received the appropriate treatment. The complaint must be directed to the County Medical Board, which is the local representative of the Norwegian Board of Health.

The Mental Health Care Act regulates administrative control by supervising commissions and judicial control by court proceedings for patients under compulsory treatment. Mentally-ill patients receiving compulsory treatment have the right to be assisted by a lawyer when making a complaint to the supervising commission, or in case of court proceedings.

Patient safety and compensation

Compensation

The NPE has covered and handled patient injury compensation on behalf of hospital owners since 1988 and for and municipal authorities since 1992.

The decisions made by the NPE are binding on the hospital authorities and municipalities, but can be appealed by a complainant to The Patients' Injury Compensation Board. The Board's decision can also be brought before the civil courts by the patient. The system, including the assessed compensations (by the NPE, the Board or the court), is financed with contributions from both hospital owners and municipal authorities. The disbursement varies from Nkr 5000 to more than Nkr 7 million. In 2003 the average disbursement was Nkr 361 000.

A provisional scheme regulates claims against public hospitals, municipal health services, first-aid stations and public general practitioners. In January 2003 the Patient Injury Act came into force. This act regulates claims against the whole health care system, but actively regulates only claims against the public health system. Compensation for injury is assessed according to the terms of the act, and mostly covers financial loss. The principal element of the new law is to assess a certain degree of liability regardless of fault. However, it is not necessary for patient to prove that the provider has caused actual harm. The NPE plays an active part in the handling of the case and in establishing possible grounds for liability. In cases of harm due to vaccination, the burden of proof is shifted, and lies in all respects with the NPE.

The Patient Injury Act is, at present, active only in claims against the public health system and private health care is not yet included in the Norwegian System of Compensation to Patients. According to the Health Care Personnel Act, health personnel who are authorized or licensed to run a private practice must take out insurance to cover any financial liability to patients that may arise in connection with the delivery of services. Compensation for harm caused within the private health care sector is organized and handled by private liability insurance, and patients still have to prove that harm has been caused by neglect on the part of the provider.

Of the patient complaints considered by the NPE in 2003, most of the claims for compensations were from patients with orthopaedic injuries (40%), followed by oncology (14%), where most patients claimed for compensations because of delayed diagnosis and treatment, the last two groups were related to diseases of digestive and cardiovascular systems (both contributed to 8% of the claims). In 2003, the NPE considered 2216 claims for compensations of which 34.3% were approved. In most of the cases (53.3%) that were upheld, the claims related to the treatment received: either that the treatment failed, or that the final result was not acceptable or faulty etc. Some 23.1% of the cases were about infections contracted after the treatment, and in a third category, 18.5% claims of late or wrong diagnosis (NPE 2004).

Patient safety

The Specialist Health Care Act states that every hospital must have a quality assurance commission as part of its mandated system of internal control. A similar requirement is not defined for primary health care. The function of this commission varies from hospital to hospital. In addition, some institutions have quality subcommittees for each department. Usually, this kind of commission initiates and promotes quality standards at the hospital. However, commissions are not themselves responsible for quality, and the sole responsibility rests with the line management organization, from the physician and nurse meeting the patient through the chief of department up to the hospital director. The Specialist Health Care Act states that there should only be one responsible leader at each level of the organization.

Health institutions and/or the authorized or licensed health personnel must notify the public authorities as soon as possible, in writing, of severe injury to a patient caused by the delivery of health care, or where injury inflicted on one patient by another.

According to the Medicine Act, physicians and dentists must report adverse drug reactions to the Norwegian Medicines Agency. Furthermore, all marketing authorization holders in Norway are obliged to report such reactions in accordance with EU regulations. As of 31 January 2003 all reports of adverse drug reactions involving medicinal products for human use should be transmitted electronically according to the guidelines set out by the EMEA¹ and ICH² regulations. Consumer-targeted advertising is permitted for over-the-counter (OTC) drugs and medical devices. Prescription drugs may be advertised to physicians and other health personnel, but advertising on television is not permitted under any circumstances.

The Norwegian Directorate for Health and Social Affairs has developed a national strategy called “...and it’s going to get better” (...og bedre skal det bli!) for quality improvement in health and social services, commissioned by the former Ministry of Social Affairs and the Ministry of Health in cooperation with the Norwegian Board of Health, an external group, and several other players in the field of health and social services. The strategy aims to ensure that users of health and social services receive services that are of high quality. The strategy also aims to ensure that the authorities’ policy for high quality is implemented, and that quality improvement work initiated in different areas within health and social services is coordinated and strengthened. The strategy has been inspired by similar strategies in other countries, by the work of the Committee on Quality of Health Care in America, the Institute of Health Care Improvement, and by the World Health Organization.

Patients' participation/involvement

Health care may only be given with the patients' consent unless legal authority or other legal grounds exist for permitting health care to be delivered without consent. In order for the consent to be valid, the patient must have received the necessary information regarding his or her medical condition and what the prescribed health care entails.

The Patients' Rights Act stipulates patients' rights to receive information about their medical status and the prescribed medical treatment. The patient should also be informed of any possible risks or side-effects which might result from the treatment. The information offered should be tailored to the individual and their ability to understand what is being presented, taking into account, for example, their age, maturity and experience as well as their cultural and lingual background. Health care personnel should, as far as is possible, ensure that the patient understands the meaning and content of the information given.

The patient is, furthermore, entitled to participate in the process of his medical treatment. This includes the right to choose among available and medically sound methods of examination and treatment. If an injury occurs or serious complications arise, the patient must be informed. The patient should at the same time be made aware of the right to apply for compensation through the Norwegian system of patient injury compensation.

According to the WHO survey carried out in 2002 in Norway, there was a high degree of satisfaction among the users of health care services with regard to respect, privacy and communication between the patient and health care provider. There was less satisfaction with indicators on personal autonomy in choice of health care provider, and involvement in decisions regarding the type of treatments. On the question about the way that health care is managed in Norway, the interviewees were asked to rate the system care according to their level of satisfaction. About 60% expressed satisfaction, while 14% expressed dissatisfaction with the way the health care is run on the basis of this very general question.

3 Financing

Total expenditure on health in Norway amounted to Nkr 168 billion in 2004, or Nkr 36 000 per capita. Public sector spending on health accounted for about 84% of the total. Central government, local government and the NIS are the public sources, while the private sources mainly consist of household out-of-pocket payments. The two functions outpatient dental care and pharmaceuticals are the main components of private spending. For the public sector, inpatient and day cases of curative care are the largest expenditure group.

3.1 Health expenditure

According to OECD data, the percentage of GDP taken up by total health expenditure in Norway in 2004 reached around 10% (Table 3.1). Comparing total health expenditures as a percentage of GDP, Norway ranked fourth in 2002 among the OECD countries, (Fig. 3.1). It is important to take into consideration the fact that Norway has a much higher GDP per capita than neighbouring countries. In 2001, GDP per capita was more than 23% higher than in Denmark and Iceland, and more than 37% higher than in Sweden and Finland, according to Statistics Norway. According to OECD Health Data 2003, Norway had the highest real annual per capita growth rates in health spending in the period 1990–2001 with 3.5%, followed by Iceland (2.8%), Sweden (2.1%), Denmark (1.9%) and Finland (0.5%). The reason for this high growth may be that Norway was less significantly affected by the economic downturn in the beginning of the 1990s, and that it has a political commitment to spend more money on health. GDP growth in the same period was 2.8% (1990–2001) (see Fig. 3.2).

According to the European Health for All database, Norway had the highest health care expenditure per capita among Nordic countries (Fig. 3.3) measured in purchasing power, followed by Iceland, Denmark, Sweden and Finland in 2003. In 1980, the ranking was Sweden, followed by Denmark, Norway, Iceland and Finland using the same indicator. Norway was also ranked third followed by Sweden and Denmark with regard to total health expenditures as a percentage of GDP in 1980.

A number of problems arise when making international comparisons between health care expenditures. When comparisons are made in relation to GDP, differences in both GDP and in health care expenditure must be taken into account, as well as fluctuations in the exchange rates. Finally, there are structural differences between the health services in individual countries, which, among other things, affect what is actually included as health expenditure.

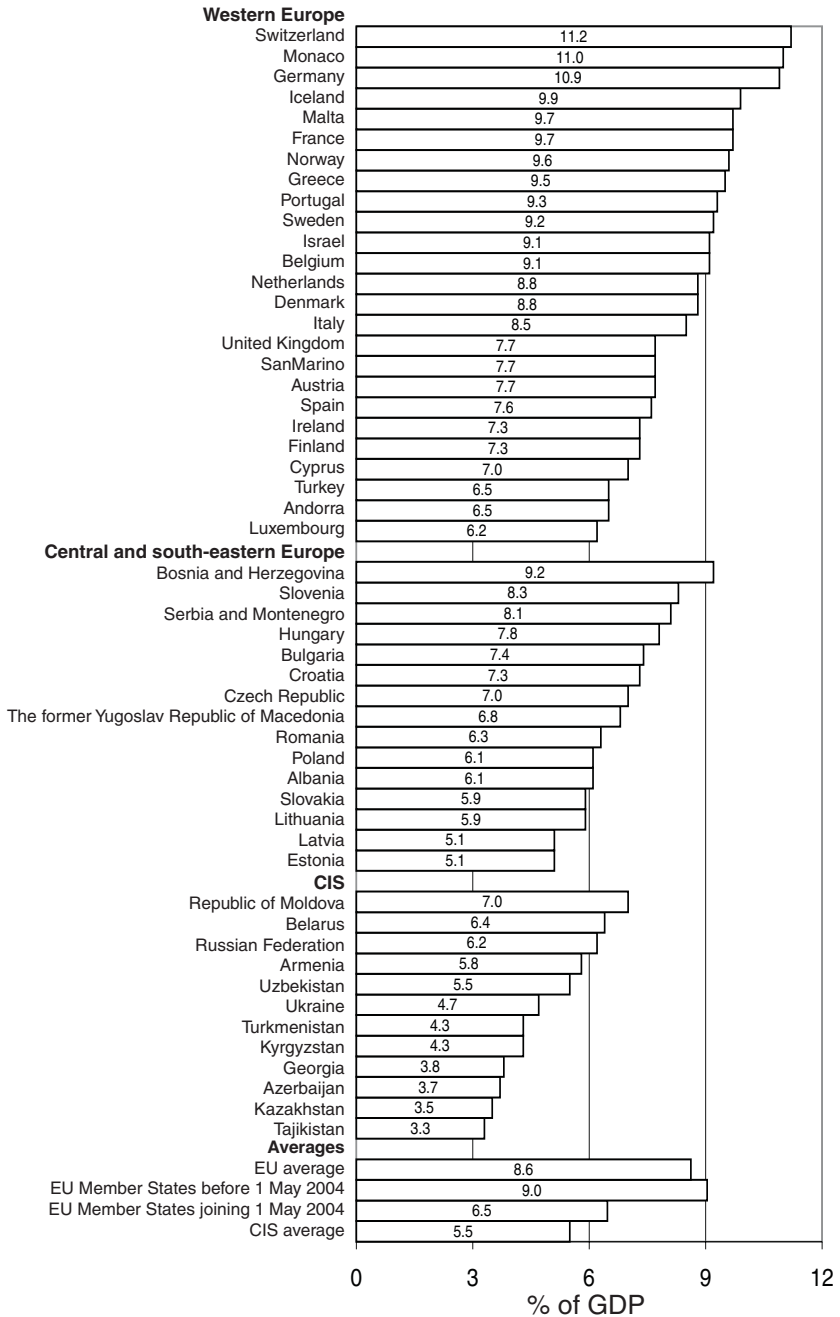
According to OECD data, total health expenditure has been increasing in Norway from 6.9% of GDP in 1980 to 9.9% of GDP in 2004 (Table 3.1).

Table 3.1 Trends in health expenditure, 1980–2004 (selected years)

	1980	1985	1990	1992	1995	1998	2000	2001	2002	2003	2004
Total health expenditure at 1995 GDP price level (in Nkr billions)	42.6	47.4	60.2	67.8	74.3	95.9	112.6	135.3	150.0	160.8	167.9 ^a
Total health expenditure per capita PPP	659	943	1 385	1 643	1 897	2 314	2 784	3 287	3 616	3 807	–
Total health expenditure as % of GDP	6.9	6.6	7.7	8.2	7.9	8.5	7.7	8.9	9.9	10.3	9.9 ^a
Public expenditure on health as % of total expenditure on health	85.1	85.8	82.8	84.8	84.2	84.7	85.0	85.5	85.3	85.5	–
Private expenditure on health as % of total expenditure on health	14.9	14.2	17.2	15.2	15.8	15.3	15.0	14.5	14.7	14.5	–

Source: OECD Health Data 2005; ^a Statistics Norway, 2006.

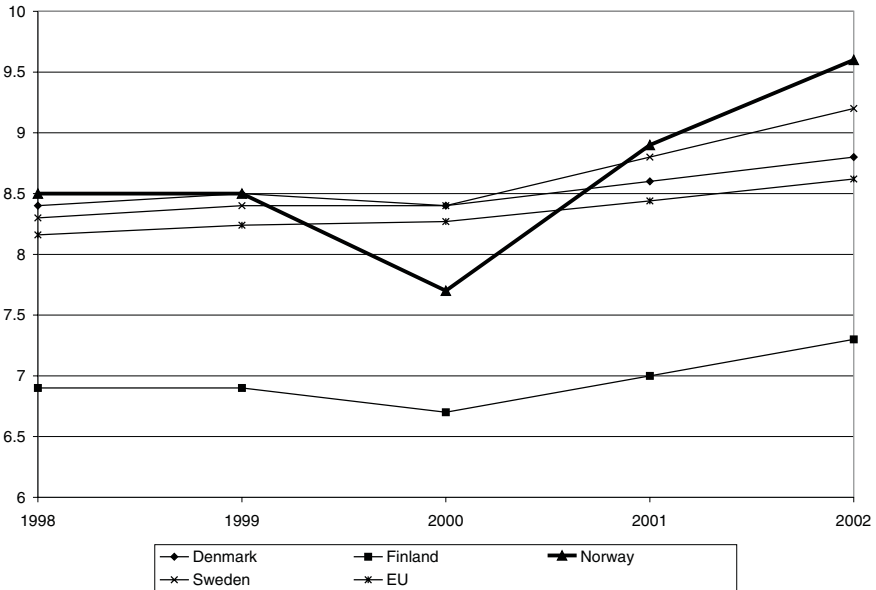
Fig. 3.1 Total expenditure on health as a % of GDP in the WHO European Region, 2002, WHO estimates



Source: European Health for All database, January 2006.

Note: CIS: Commonwealth of independent states; EU: European Union.

Fig. 3.2 Trends in health expenditure as a share (%) of GDP in Norway and selected countries, 1998–2002



Source: European Health for All database, January 2006.

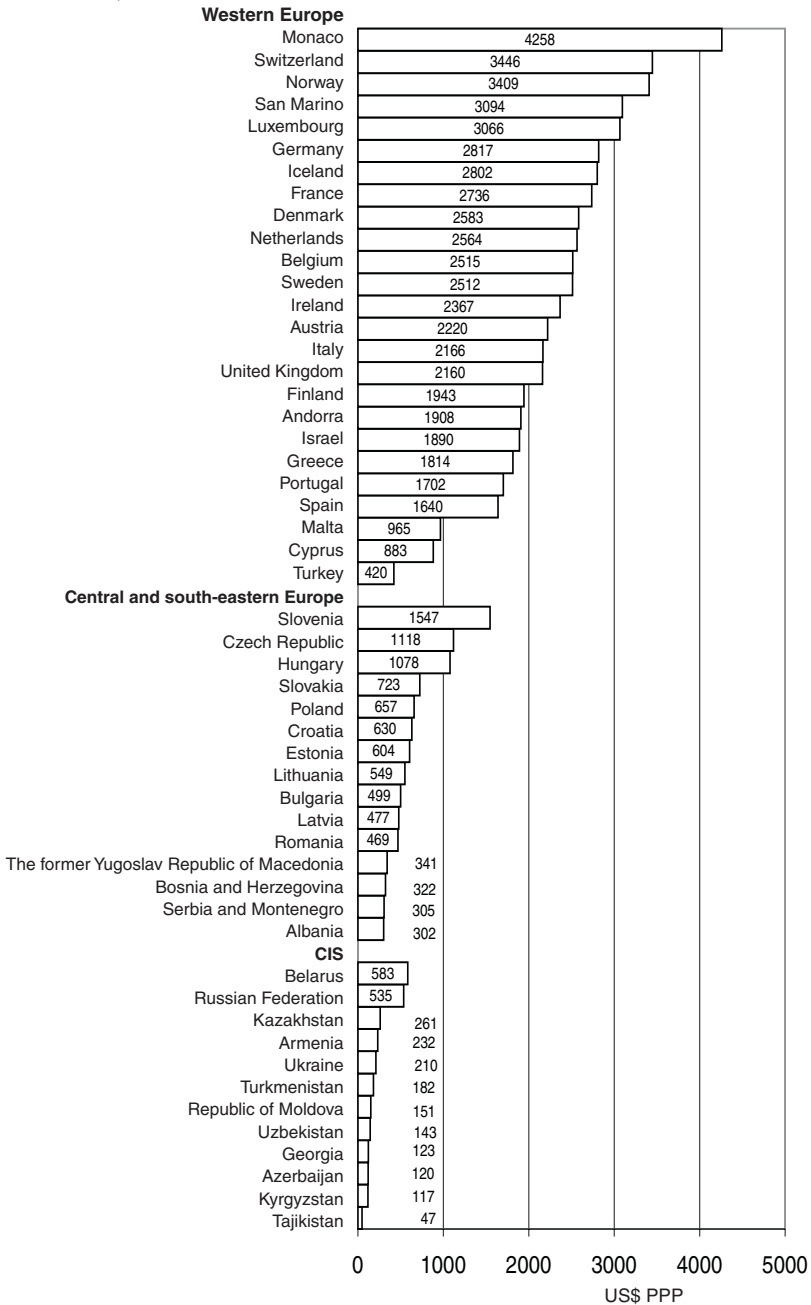
The growth in health expenditure in Norway is similar to that in other western countries and can be explained by several reasons, such as the increasing number of elderly people, higher expectations, growth in the real GDP and increasing implementation of new technology in the health sector.

The Norwegian health care system is funded primarily from taxes and transfers from central government. The municipalities and counties have the right to levy taxes on their respective population which, together with the government transfer, provide funding for primary health care. Regional health authorities depend on central government’s transfer and do not have the right to levy taxes. There is element of out-of-pocket payments, but these are mainly subsidized by the National Insurance Scheme.

3.2 Population coverage and basis for entitlement

The Norwegian health system is predominantly tax based and is built on the principle of providing all inhabitants with equality of access to services, regardless of their social status, location and income.

Fig. 3.3 Health care expenditure in US\$ PPP per capita in the WHO European Region, 2002, WHO estimates



Source: European Health for All database, January 2006.

Note: CIS: Commonwealth of independent states.

These rights are regulated by law and are also embedded in the culture of the Norwegian welfare state. Two laws – the National Insurance Act and the Social Care Act – are the statutory mainstays of Norwegians’ social rights. No politicians have yet challenged this system, neither have any real alternatives been suggested in modern times. Residents from the European Economic Area (EEA) and from the EU have in principle the same access to health services as Norwegians, and are reimbursed according to EEA regulations and some bilateral agreements. Foreigners outside of the EEA who are using the Norwegian Health care system normally have to pay the full cost for services received (if not there exists any bilateral agreement).

Certain types of treatment must be considered, by a physician, as either essential or beneficial in order to qualify for public funding. For example, cosmetic surgery can only be performed free of charge if a physician decides that it is necessary on psychological grounds. These decisions are taken by individual physicians on a case-by-case basis. There is no approved list of benefits provided by the statutory health care system in Norway.

In practice, the statutory health care system does not pay for “alternative” treatment (for example, zone therapy, kinesiology, homeopathy and spa treatment), or spectacles (unless the patient has very poor vision). The costs of physiotherapy and dental care are only partially covered by the statutory health care system. Statutory reimbursement of pharmaceuticals is based on an approved positive list called “blue prescription list” of drugs drawn up by the National Medicines Agency (see section on pharmaceuticals, section 6.6).

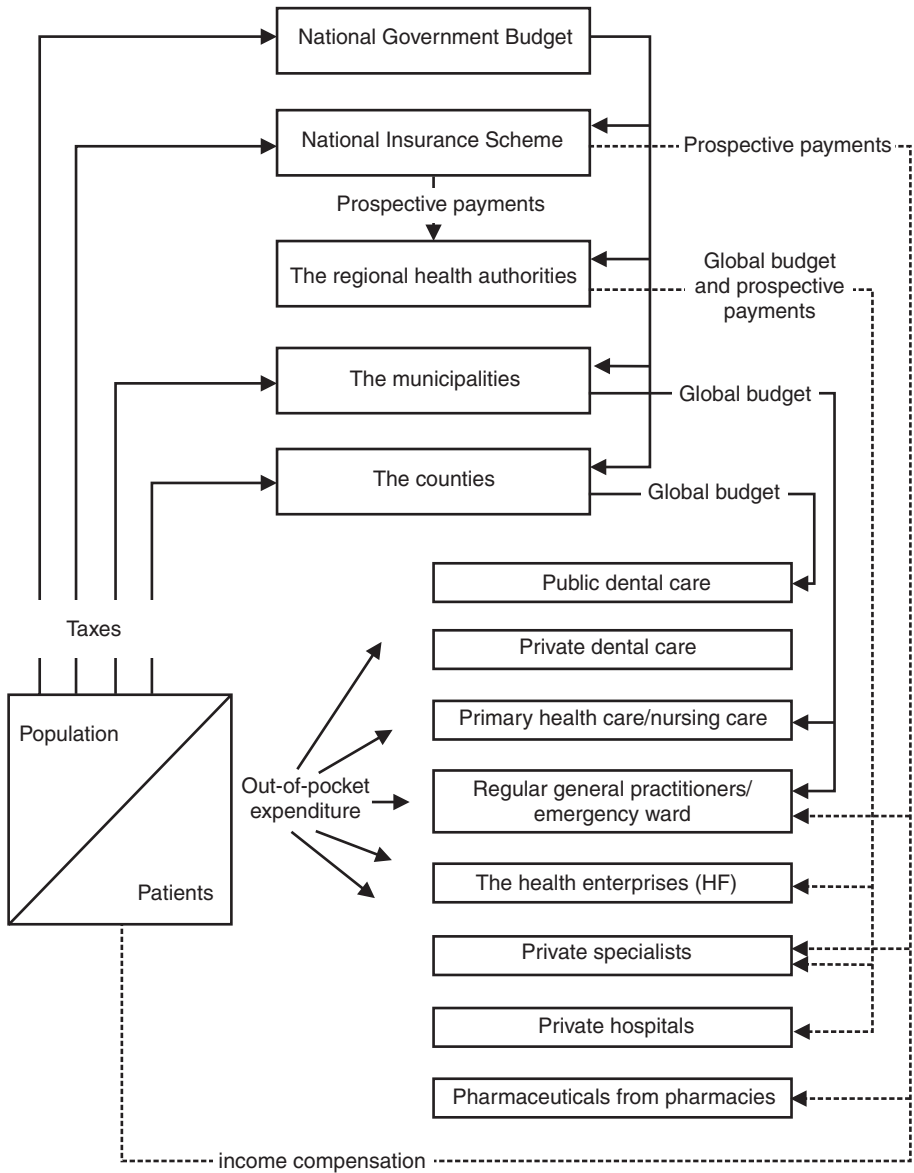
The National Insurance Scheme coverage

All persons who are either residents, or working as employees in Norway or on permanent or movable installations on the Norwegian Continental Shelf must be insured under the National Insurance Scheme. The same applies to persons living in Svalbard (Spitsbergen) and Jan Mayen who are employed by a Norwegian employer or who were insured under the National Insurance Act prior to their stay in these areas. Insurance is also compulsory for certain categories of Norwegian citizens working abroad.

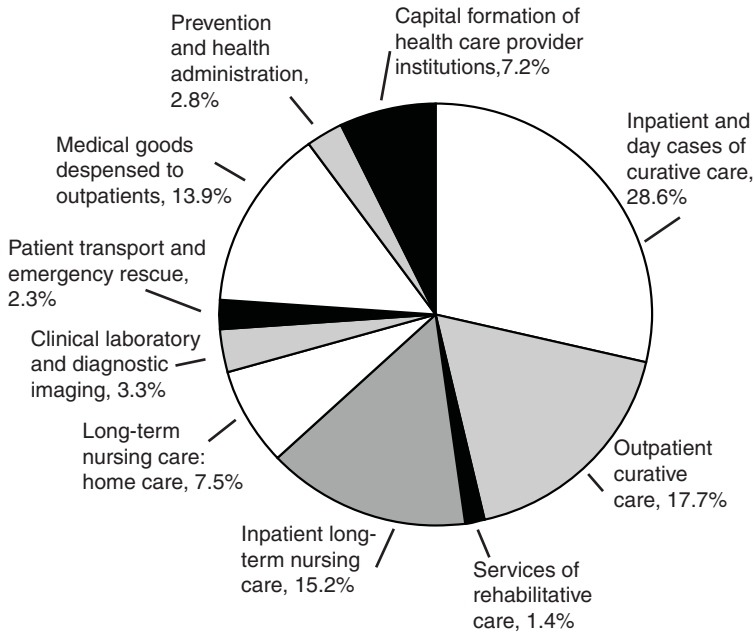
According to the EEA agreement, Norway follows the EU regulations with regard to social security. Employees, the self-employed and freelancers are all members of the social security system. Those who do not fulfil these requirements can apply for voluntarily membership in the NIS if their stay exceeds three months.

Persons insured under the National Insurance Scheme are entitled to retirement, survivors’ and disability pensions, basic benefits and attendance

Fig. 3.4 Financial flow chart, 2004



Source: Adapted from NOU: 3 (2005).

Fig. 3.5 Health expenditure by function, 2004

Source: Statistics Norway, 2005. Health accounts 1997–2004.

benefit in case of disability, rehabilitation or occupational injury. There are also benefits for single parents, cash benefits in case of sickness, maternity, adoption and unemployment, and medical benefits in case of sickness and maternity, as well as funeral benefits.

All insured persons are granted free stay and treatment, including drugs, in public hospitals. The patient has to pay part of the cost of treatment by a general practitioner or for specialist treatment as an outpatient, to visit a psychologist/psychiatrist, for the prescription of certain drugs and for their transportation costs in connection with examination or treatment. The municipality and/or the National Insurance cover the major part of the expenses. There are certain exemptions from cost-sharing provisions for special diseases and groups of people. Children under the age of 7 are exempt from cost-sharing for treatment given by a physician or physiotherapist, essential drugs and travel expenses. Children under the age of 18 are exempt from cost-sharing for psychotherapy and dental treatment. Since 1 January 2003, those who receive minimum retirement or disability pensions can receive their essential drugs and nursing requisites free of charge. Routine medical examinations during pregnancy and after delivery are also free.

The right to maternity leave is laid down in the Working Environment Act of 1977 (arbeidsmiljøloven). There are two main conditions which must be met in order to receive maternity benefits: the recipient must be a member of the NIS and must have been in paid work for at least six of the ten months prior to the start of the benefit period. Maternity benefits are equivalent to 100% of the recipient's salary, up to a maximum of six times the NIS basic amount (NIS basic amount = Folketrygdens Grunnbeløp (G)), e.g. Nkr 340 000 (in 2005 1G, the basic amount, equalled Nkr 60 699 per year – the amount is regulated every year). Maternity benefit is either 42 weeks at 100% of the weekly wage, or 52 weeks at 80%. The mother can start her benefit period 12 weeks before expected delivery; four weeks of the benefit period are reserved for the father. If the conditions for receiving maternity benefits are not met, a one-off tax-free payment of Nkr 33 584 per child (2003) is made to mother. This sum is set by parliament every year. Adoption of children under the age of 15 gives the same rights as mentioned above.

A person has a right to sick leave after he or she has been employed for at least four weeks. Self-employed persons and freelancers have the right to sick pay after 17 days of illness, freelancers on the condition that they have income from their work. In order to be eligible for sick pay, one must be unable to work due to illness, injury or disfigurement. Social problems do not meet the conditions for sick pay. Sick pay is equal to one year's salary up to a maximum of six times the NIS basic amount, e.g. Nkr 340 000 (the basic amount for 1 G equals Nkr 60 699 per year (2005)). The amount paid out is dependent on the degree of disability, on a scale from 20% disabled to 100% disabled. Sickness benefit ceases after one year, after which time the recipient has the right to: cash for rehabilitation and/or vocational occupational rehabilitation if a change in occupation is deemed necessary, or a pension in case of permanent disability.

Despite the small market for voluntary health insurance in the country (see section 3.3) there are many private insurance companies offering voluntary insurance in order to complement the benefits from the NIS. This insurance is not meant to cover specific services that are excluded from the NIS, but is merely extra monetary benefits or extra guarantees. The most common include private pension insurance supplementing the pension benefits offered by the NIS. Sick pay insurance is common among self-employed persons, as are life insurance and some dental care schemes.

Patients can appeal on rationing decisions; this is enshrined in the Patients' Rights Act of 1999, explained in section 2.5. It is also possible to appeal against any decisions made by the National Insurance Administration.

As can be seen, the NIS covers many risks related to loss of income and expenses. The total expenses of the NIS in 2002 were Nkr 205 273 million (in

2004: NKr 228 255 million). This amount represents more than 35% of total public expenditure and approximately 13.2% of GDP. More than a quarter of its 2002 budget (NKr 56 420 million) was derived from a specific component of tax revenues paid by employees (called Membership of Social Security), while the other three-quarters came from employers' payroll contributions (NKr 79 411 million, 40% of the total) and general taxation (about NKr 69 442 million, 33%). The major components of NIS expenditure consist of the retirement pension system (NKr 72 686 million in 2002) and the pension system for the disabled (NKr 38 593 million), while health care expenditure by the NIS represented almost NKr 20 000 million in 2002. About 1.4 million Norwegians received social security benefits in 2002 and 21% of those had social security payments as their main source of income.

The National Insurance Administration (administrative body for the NIS) has an administrative department which manages the financing of public health services, i.e. GPs, specialists, pharmaceuticals and others. The National Insurance Administration is not an independent body, but is formally responsible to the Ministry of Labour and Social Inclusion. Readers should be aware that there is no correlation between the amount that inhabitants contribute to the NIS and the health care services they receive.

Prioritization

There are no explicit regulations as to what the public health care system should or should not cover.

A priority commission was established in the 1980s in order to develop proper instructions for priorities and benefits in the health care system. A Royal Commission (NOU 1987:23)⁶ presented proposals for criteria and priority levels, which initiated a public debate and drew attention to the difficult question of prioritization. In practice little was done, the only results were a waiting list guarantee and a treatment guarantee. In 1997, another Royal Commission (NOU 1997:18)⁷ presented criteria for priorities in the health care system. The main difference between the two commissions was that the latter took into account the costs.

Based on the work of the second commission (NOU 1997:18), parliament passed the Patients' Rights' Act, and priority regulation was established whereby three principles are taken into consideration when deciding if a patient is entitled to health care. These are the degree of severity, expected effectiveness and the

⁶ Lønning I (Norwegian name)

⁷ Lønning II (Norwegian name)

costs in relation to the expected outcome of the treatment. In spite of the fact that the commission's intention was to establish a workable priority system, little has been done to implement its recommendations. The outcomes included the revision of the waiting guarantee and the new mandate given to the former Public Hospital Board (Statens sykehusråd) which was renamed the National Board for Priorities in the Health Care System (Nasjonalt råd for prioriteringer i helsevesenet). So far this Board has had little practical meaning.

It is possible to conclude that the priority debate which lasted for over fifteen years produced very few practical results. This illustrates the political difficulties faced in making decisions as the population gains more rights and makes higher demands (Schiøtz 2003).

3.3 Revenue collection/sources of funds

Compulsory sources of finance

The most important feature of the Norwegian health care system is the predominance of tax-financed public provision. The entire resident population of Norway is covered with regard to needs and the financial burden of using health care services, and there is only a small connection (limited to out-of-pocket payments) between individual health risks and costs. There is no specific health tax in Norway.

Different political bodies play a role in the intermediate financing flow: national government, the counties and the municipalities (with the right of taxation, in addition to central government taxation), and the National Insurance Scheme (mainly fee-for-service financing in health care). Local authorities finance non-medical services for elderly people and those with disabilities.

As shown in Table 3.2, the flow of revenue has been very stable over the past 20 years. Sources for health care include taxes (mainly based on proportional income), indirect taxes, the national social insurance system and private expenditure (that is, out-of-pocket payments and private insurance) (see Fig. 3.6.)

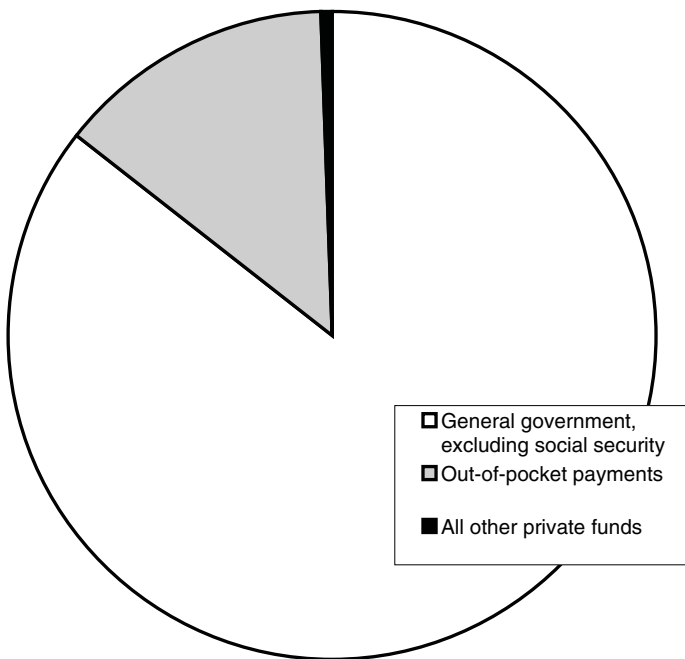
The total tax-on-GDP ratio in 1999 (43.5%) for Norway was slightly higher than the weighted EU average (41.6%), and far higher than the US and the OECD averages. On the other hand, Denmark and Sweden have a higher tax-on-GDP ratio than Norway (50.4% and 52.2%, respectively). When the ratio is adjusted for resource rent income from the petroleum sector, the 1999 tax ratio for Norway increased to 45.7%.

Table 3.2 Sources of revenue as a percentage of total expenditures on health 1980–2003, selected years

Public expenditure on health %	1980	1985	1990	1995	1998	1999	2000	2001	2002	2003
Government, excluding social security	85.1	85.8	82.8	84.2	84.7	85.2	85.0	85.5	85.3	85.5
Private expenditures on health										
Out-of-pocket payments	14.9	14.2	14.6	15.2	14.8	14.3	14.5	14.0	14.7	14.5
Other private funds	0	0	2.6	0.6	0.5	0.5	0.5	0.5	0	0
Total:	100	100	100	100	100	100	100	100	100	100

Source: OECD Health Database 2004.

Fig. 3.6 Total health expenditure from different sources, 2003



Source: OECD Health Database, 2003, 2nd edition.

Differences in social security systems may to some extent explain why the tax-on-GDP ratio differs between countries. The Nordic pension systems have high gross pension benefits. On the other hand, most pension benefits are taxable.

The tax-on-GDP ratio will be higher in countries where pension benefits are taxable compared to countries where those benefits are given on a net basis, even when the net benefits do not differ to any great extent.

The total collected tax income for the state, municipalities and counties was estimated at Nkr 685 billion in 2003. Around 87.2% of the total amount of the tax income goes to the state, 11% to the municipalities and 1.5% to the counties. The largest part of the municipalities' and counties' tax income comes from income and property tax from personal taxpayers (NOU 2003:9).

The Norwegian tax system is characterized by its relatively high level of indirect taxes. Value-added tax (VAT)⁸ and excise duties represent about 30% of the total tax revenue. Personal income tax and tax on net wealth levied on individuals represent about 35% of the total tax revenue. Corporate tax, including employers' social security contributions, amounts to approximately 18%. Taxes levied on the petroleum activity represent about 13.5% of the total tax revenue.

The main body for collecting taxes in Norway is the Norwegian Tax Administration (Skatteetaten). This is placed under the Ministry of Finance and comprises the Directorate of Taxes (Skattedirektoratet), 19 county tax offices, 18 tax collectors' offices, 431 municipality tax offices and population registration offices.⁹

After parliament approval, the central government sets the municipalities' and counties' minimum and maximum tax range. Experiences so far have shown that all municipalities and counties are setting the maximum tax rates allowed (NOU 2003:9). Income is taxed according to a progressive rate structure with marginal tax rates up to 55.3%, exclusive of employers' social security contributions (64.7% including employers' social security contributions). Capital income from individuals and businesses is taxed at a uniform rate of 28%. No taxes are earmarked for health care.

Taxpayers who can prove extra expenses due to permanent illness are entitled to a special deduction in the tax base (for ordinary income tax) equal the amount of the expenses. The extra expenses must be at least Nkr 6120 and there is no maximum limit. About 105 000 taxpayers were entitled to such deductions in 2001. The average amount was Nkr 12 700. There is no income tax up to Nkr 24 499 per year.

⁸ At the time of writing, the ordinary rate of VAT was 25% of sales value.

⁹ As an illustration of the efficiency of tax collection, by 31 December 2003, 98.6% of all tax demands for the fiscal year 2002 had been collected (Norwegian Tax Administration 2004, personal communication).

Voluntary health insurance

As all inhabitants are covered by the state system, voluntary health insurance does not play any significant role in Norway. Some attempts have been made to provide complementary health insurance, specifically targeted at patients who would like to avoid waiting for hospital treatment. A number of private health care centres are opening up in urban areas of Norway, whose services are available only to members. These might be compared to a form of health insurance. Medical technology has increased the possibilities for treating diseases in outpatient departments and, as a result, some private health care suppliers benefit from increasing demand both for general and specialized services. Thus far, Norwegian statistics do not provide data on private specialists who do not receive public funding, or on expenditure on voluntary health insurance. At present, there are few private voluntary health insurance schemes which guarantee hospital treatment at a private hospital if a public hospital cannot perform the same treatment within 28 days. Recent estimates show that around 30 000 Norwegians have joined some form of voluntary insurance (these are often included in working contracts).

Out-of-pocket payments

Medical benefits during sickness and maternity are partially funded by the NIS. All insured persons are granted free stay and hospital treatment, including medicines, as set out in the Specialist Health Care Act (1999). In the case of primary and emergency care, the provisions of the Municipalities Health Services Act (1982) and the National Insurance Act (1997) apply.

Dental care for adults is the one area where out-of-pocket payments are significant, amounting to some NKr 6.8 billion for the year 2003 (75% of total spending). These usually take the form of co-payments, but there are also elements of balance billing where the NIS subsidizes services for prioritized patients (see section 6.12). Persons under the age of 18 years old are entitled to free public dental care organized by the counties in collaboration with the municipalities.

There are no out-of-pocket payments for inpatient care in Norway. Most out-of-pocket payments relate to consultations with specialists and general practitioners, and ambulatory care. There are also out-of-pocket payments for radiology and laboratory tests, and for transportation expenses related to treatment. The levels out-of-pocket expenses are set nationally. Table 3.3 gives an overview of the most common out-of-pocket payments for medical treatments in the public health care system. There are, however, certain exceptions from cost sharing for special diseases and specific groups of people.

A cost sharing ceiling was introduced in the early 1980s. The ceiling is set by parliament each year: in 2006 it was Nkr 1615. When the ceiling (“egenandelstak 1”) has been reached, a card is issued, which entitles the holder to free treatment and benefits, for the remainder of the calendar year. Cost sharing for children under the age of 16 is included with one parent’s ceiling. Children under the age of 12 are generally exempted from cost sharing for health services. In 2005 more than 1 million people were covered by “egenandelstak 1”.

The arrangements with “egenandelstak 2” follow the same model as mentioned above, and guarantees that no one has to pay more than Nkr 2500 in out-of-pocket expenses for physiotherapy treatment, refundable dental treatment (except oral surgery), treatment at rehabilitation centres or treatments abroad. At the end of 2003, 3340 persons were covered by “egenandelstak 2”.

“Egenandelstak 1” and “egenandelstak 2” are not related to individual income. Everybody pays the same amount, before a free card is granted.

Municipal services, such as home care for the elderly and disabled, and inpatient care of the elderly at nursing homes, are among the services that are not included in the ceiling for cost sharing by the NIS. These social care services are usually subject to considerable out-of-pocket expenses. For instance, residents in nursing homes pay around 75%–85% of their income to the municipalities. Currently there are 40 000 people living under these conditions.

Under the step price system for prescriptions (trinnprissystemet) (see section on pharmaceuticals) the patient has to pay the difference between the reimbursement price and the actual price (this cannot be added to the free card), if the patient wants more expensive medicine.

There are no official statistics on the total sum of out-of-pocket payments, and such estimates are subject to considerable methodological problems. According to the OECD Health Database the share of out-of-pocket expenditures in the health care system is about 15%.

It is difficult to identify the explicit objectives of cost sharing in the Norwegian health care system. Informal payments are not perceived as a problem in Norway and no research has been carried out in this area.

External sources of finance

External financial assistance for the health sector which may take the form of loans and grants from bilateral or multilateral organizations is not relevant for the present day Norwegian health care system.

Table 3.3 User charges for health care services, 1 January 2006

Types of cost-ceilings	NKr
–"Egenandelstak 1"	1.615
–"Egenandelstak 2"	2.500
The limit for contributions	1 600
Physician	
– Consultations, GP/emergency ward	125 (day) 210 (night)
– Sick call, GP/emergency ward	150(day) 235 (night)
Home visit by GP/emergency ward	170 (day) 280 (night)
Home visit by GP specialist in general practice	195 (day) 305 (night)
– Specialist/ambulatory care	265
– Query/advice	35
– Laboratory tests	47
– X-rays	200
Physiotherapist	
– Ordinary examination	135
– 40 min exercise treatment	135
Treatment of special diseases	50
Psychologist	
– Ordinary user charge (½ or 1 hour)	265
– Session 1½ hours	397
– Session 2 hours	530
– Session 2½ hours	662
– Session 3 hours	795
Group therapy	
– Minimum 2 hours	265
– Minimum 3 hours	397
Stay at rehabilitation institution	NKr 120 per day
Purchasing of pharmaceuticals/medical equipment with blue prescription	36% of the value of prescription, but not more than NKr 500 per prescription
Travelling in connection with examination and treatment	NKr 115 (one way), both ways NKr 230
Travelling out of region in connection with hospital choice "Fritt sykehusvalg"	400 (one way). Not to be refunded
Pyment, In Vitro Dertilization	1 500 per try. Not to be refunded.

Source: National Insurance Administration, 2005.

Note: Stay in hospital: No out-of-pocket payments. Further it is possible to be charged for minor services and materials that are not to be refunded. Children under the age 12 do not pay out-of-pocket payments.

Other sources of finance

There are no major sources of finance for the Norwegian health care system other than those described earlier. The only other notable sources are private

fund transfers and gifts from organizations, private foundations or individuals. For instance in 1997, the annual humanitarian campaign on the Norwegian television public broadcasting company, NRK, known as the “TV-aksjonen” collected money for the Norwegian Cancer Association, which was also directly benefited by the public health system’s work on cancer. Typically, there is a private grassroots initiative, collecting money for the local hospitals so that they can buy special equipment and units (for instance one charitable foundation sponsored a palliative care unit at a public hospital), or money transfers to medical science projects (for instance, infant mortality studies). In some areas, such as the rehabilitation treatment of substance abusers, some providers rely on sponsorship from private charitable organizations. Nevertheless, none of these sources are financially reliable, but are rather ad-hoc initiatives that do not have fundamental financial significance for the health care system.

3.4 Pooling of funds

Pooling agencies and the mechanism for allocation funds

According to the law, all public services must be carried out within the approved annual budget. For the government’s operations, this is set out in section 75 of the constitution, for the municipalities’ and counties’ operations in the Municipality Act of 25 September 1992, and the Regional Health Authorities Act of 15 June 2001. In addition, the Ministry of Health and Care Services provides directives for principles for budget and accounts to the municipalities, counties and regional health authorities. After the annual budget has been passed by parliament it is then allocated to three levels, i.e. the regional health authorities, the municipalities and the counties.

There are significant differences between municipalities and counties both in the level of income and the level of expenditure. It is a national objective to offer citizens a high level of public services with equal standards regardless of where they live. Therefore, there is a considerable degree of redistribution of income between the municipalities and the county authorities. This is achieved through the General Purpose Grant Scheme (Inntektssystemet for kommuner og fylkeskommuner), which ensures both a fair distribution of income, and regional growth and development. This is essential in order to maintain an efficient and autonomous local government sector.

The functioning of the equalization of expenditure mechanism to fully compensate involuntary costs is to a large degree determined by the characteristics of the population (i.e. demographic and social criteria) and the

number of inhabitants and population density (in favour of small and sparsely populated municipalities).

The variation in costs between the municipalities may be illustrated by a survey from Statistics Norway, which showed that the average expenditure for primary physician services in 2002 was Nkr 738 per inhabitant. In comparison, municipalities with a population of fewer than 2 000 reported an expenditure of Nkr 2 300 on average per inhabitant.

Allocating resources for specialist health care has been a challenge. When the state took control of the hospitals from the counties, the opening balance sheet (“Åpningsbalansen”) in 2002 was based on the value of the hospitals’ fixed assets (buildings and equipment). Experts (chartered accountants and real estate professionals) used replacement values and these fixed assets in the opening balance sheet were, therefore, given a relatively high value. Depreciation has become a considerable item in the hospitals’ profit and loss systems. Some argue that the depreciation factors make it impossible for the hospital to avoid negative profit and loss accounts without it having an adverse effect on patient care. There are ongoing discussions between the Ministry of Health and Care Services, the Ministry of Finance and the regional health authorities with the aim of reaching agreement as to the right values in the opening balance sheet from 2002 and the depreciation periods. Grants following hospital reform in 2002 have partly been based on the counties’ expenditures on health (that followed General Purpose Grant Scheme) and partly based on political decisions and negotiations.

The public purchasers/providers of health services do not in principle bear any financial risks. The municipalities, counties and health enterprises in the regional health authorities cannot go into bankruptcy. If a municipality falls into severe economic problems, the government will dictate much of its ongoing operations, and the health enterprises will have to resort to dissolution of the board.

The government outlines its budgetary plans each October for the following year, and parliament usually approves the budget in December. In principle, the state budget is a global budget intended to cover all expenses for the following year. But there is a strong tendency for parliament to vote for an increase in the level of funding above that outlined in the budget proposal, especially for hospitals. Furthermore, there is supplementary funding from the parliament during the fiscal year, for instance in April/May in accordance with the revised national budget (Revidert nasjonalbudsjett, rnb) that is made available during the operational year; surveys show that the annual increase for hospitals from 1990 to 2001 averaged 5.6% above the original budget (Slåttebrekk and Aarseth, 2003). It can be concluded that the budget is soft, and there are, as yet, no formal

penalties for overspending (Slåttembrekk and Aarseth, 2003). One factor which may be relevant is the fact that Norway has been run by minority governments during the last 15 years.

3.5 Purchasing and purchaser–provider relations

Integrated purchaser–provider relations are the dominant feature of the Norwegian health care system. It is, perhaps, difficult to see where the dividing line lies between purchaser and provider, due to the fact that the systems are mainly publicly owned. However, there is a purchaser–provider split trend in Norway.

A survey from 2004 (RO 2004) showed that 40 of the 431 municipalities had introduced a purchaser–provider model. This represents some 47.8% of the population. No municipalities with fewer than 10 000 inhabitants had established this model. However, only 7 out of 44 purchasers know the price of the services when they place orders with the providers, while around 50% of the municipalities sometimes make use of private providers in their purchaser–provider system. For instance, Kristiansand municipality has established a purchaser–provider system for nursing care whereby the purchase order for services is followed by a cash flow to the providers. This model has also been adopted in Oslo.

Contracts between municipalities and private providers are a very important tool in guaranteeing good quality for service users, and also in securing good cooperation with other parts of the health system. A survey conducted during the 1990s (Bogen and Nymoene 1998) showed that the municipalities set up different types of contracts. For instance, contracts with providers for nursing care services were different to those that dealt with the delivery of technical services. For nursing care services the municipalities have chosen “soft contracts” that allow for a degree of flexibility between the municipality and the provider, meaning in practice that these contracts are open for more rapid changes depending on the needs of the patients.

The municipalities have a contractual relationship with the GPs, who are part of the national regular GP scheme. These contracts regulate the relationship between the GP and the municipality. For instance, the municipality has the right to order the GP to do municipality health care work (a maximum of 7.5 hours a week) if this is specified in the agreement, however NOU: 3 (2005) shows that most of the municipalities do not, in practice, exercise this right fully.

The health enterprise model is to a certain degree based on a purchaser–provider division since the regional health authorities purchase health services, and the health enterprise provides the specialist health services. Further, the regional health authorities own the health enterprises and are thereby responsible for the state’s provider function. The regional health authorities draw up the guidelines on the needs to be covered, and ensure that those needs are followed up through their steering and ordering functions.

There has been some criticism of the purchaser–provider division in the regional health authority model (Byrkjeflot and Grønlie 2004; OECD 2003). The relationship with private providers has been central in the OECD’s questioning. The regional health authorities have a contractual relationship with many radiology/laboratory units, private specialists and rehabilitation units. In 2005, action was taken to make a clearer distinction between the regional health authority and the health enterprise. This follows from St.prp. nr 1 (2004–2005) from the Ministry of Health and Care Services. Both the purchaser role and elements for provider rest with the regional health authority. A complete division between the two roles would have necessitated extensive use of auctions and competition tools. The opinion (expressed in St.prp. nr 1, 2004–2005) is that in the greater part of the country, it is impossible to establish real competition for much of the specialist health services; this system would require a large contract system, and there is no clear evidence that this result would give better health care services.

The Ministry of Health and Care Services’ letters of instruction of 2002 and 2003 to the regional health authorities stress the importance of ensuring the smooth functioning of the integrated model, especially with regard to the relationship with private agencies. In 2005, the government tried to make the distinction between the regional health authorities and the health enterprises clearer. For instance, an individual may not serve on a regional health authority board and on a subordinate health enterprise board at the same time. In addition, from 2005 the regional health authorities have had to establish in their organization a clear distinction between the role as owner of the health enterprise and their responsibility to care for health services.

It is notable that currently there is no provider–purchaser model between the municipalities (primary health care) and the regional health authorities (specialist health care). However, a Royal Commission (NOU 2005:3) suggested some organizational models regarding different purchaser–providers structures, one of which was that the municipalities and the regional health authorities should together act as purchaser for all areas of the health services.

3.6 Payment mechanisms

Block grants are made from the public purse, and before these can be received, contracts must be drawn up between the supplier and the local authorities (municipality, county, regional health authorities). Other areas in the payment mechanism (fee-for-service or DRG financing, out-of-pocket payments) are universal, and there is little room for local variations.

Paying for health services

Primary care

The main source of funding to the municipalities is via block grants from the state. Prior to 1986 these block grants were made as sector transfers, with some earmarking on the grants, but after 1986 this was replaced by a single big block grant transfer. The state has a distribution formula which determines the amount of grants that are distributed to the municipalities. The grant is calculated using a weighting system to compensate for variations in the demand for municipal services and cost differences in respect of producing those services. The most important weightings relate to age, as the demand for health care depends on demographic characteristics.

Variation in need, cost and municipal ability are all factors that affect the total expenditure on health care. For instance, an increase in the proportion of elderly requires a greater amount of nursing and other care, which in turn leads to a higher demand on resources. In addition, it is much more expensive for rural municipalities to organize medical emergency call services than for those in urban areas owing to a scattered workforce and the geographical distances that must be covered. There are three funding sources for emergency services: from municipalities, in agreements with the GP, from patients' out-of-pocket payments, and via reimbursement from the NIS. The physicians' fees are based on the same fee-for-service scheme, as explained later in the section on paying health care personnel.

Usually arrangements with the fee-for-service schemes are regulated by directives. Normally if the health worker has a contractual relationship with the municipality he or she receives the NIS subsidy directly, otherwise (if employed by the municipality) the municipality receives the NIS subsidy.

The NIS also partly pays fee-for-service for the services provided by psychologists/psychiatrists and physiotherapists, who are often self-employed and receive grants directly. Midwives have some tariff grants from the NIS for providing birth control services. There are two types of payments with regard to the primary care emergency ward:

1. The physician receives the NIS subsidy (fee-for-service) directly (on-call physicians).
2. If physician is salaried and employed by municipality (LV centres) the municipality receives the NIS subsidy from the tariffs

The counties' block grants, reimbursement from the NIS and a small amount of out-of-pocket payments finance the public dental health care.

Specialist health care

Hospital financing has been developed in the following way:

- 1970–1980: a period with *per diem* reimbursement. A combination of decentralized responsibility and *per diem* funding from the state gave strong incentives for the counties both to increase existing hospital activity and to invest in hospital buildings and equipment.
- 1980–1997 the period of block grant financing. Central government gave fixed annual block grants to the county councils for funding hospitals and other activities (e.g. secondary schools, culture and transportation). The grants were set according to a set of criteria such as county tax revenues, the age composition of the population and population density. The change in funding modified the incentives to contain costs, and as county councils became responsible for the total costs in the hospital sector, more emphasis was put on cost containment.
- July 1997 – present: activity-based funding. From 1 July 1997 a fraction of the block grant from the central government to the county councils was replaced by a matching grant dependent upon the number of patients treated, the patients' DRGs, and a national standardized cost per treatment. There were several arguments for the introduction of activity-based funding (Innsatsstyrtefinansiering, ISF). First, an increase in the number of elective treatments was considered necessary in order to fulfil the waiting list guarantee adopted by parliament. Second, an increase in the central government block grant to the county councils was assumed to be insufficient because of the leakage to other sectors for which the county councils are responsible, in particular secondary schools and transportation.

Consequently, reform of the financing mechanism was sought. By introducing a matching grant to the county councils, the government hoped to balance the county councils' costs for hospital treatment relative to other services, and hence, influence the county councils' priorities towards the hospitals. In addition, and to ensure that the county councils increased their share of hospital funding, the activity-based component was set below the marginal cost of producing a DRG point. The intention was also that the activity-based funding should

be implemented as activity-based contracts between a county council and its hospitals. However, the county councils were free to decide the kind of funding mechanism they would use.

Currently the regional health authorities and the health enterprises are financed by the state, together with only a small fraction of out-of-pocket payments for ambulatory care and laboratory/radiology services.

The regional health authorities are free to set up their own system to fund the health enterprises and other institutions. However, experience so far has shown that the regional health authorities do not reallocate the activity-based funding from the state. It is, however, a principle that the prospective payment scheme is an arrangement between the regional health authorities and the state. The block grant contribution is allocated from the region to the health enterprise based on their resource needs. It is not possible to point out exactly how this allocation is conducted but it has been shown that the regional health authorities increase the block grants funding to the health enterprises based on age structure in its surrounding area.

The activity-based funding system is built on active information from the hospitals. Information on patients consists of data on illnesses and procedures according to the international classification systems (ICD-10 and NCSP). This data is then transferred to the Norwegian Patient Register three times a year. The collated information is then transferred to the Ministry of Health and Care Services, which also supervises this system. A Nordic DRG system is used to classify the patients and DRG weights are based on national average costs. The Ministry of Health and Care Services pays the regional health authorities the amount their activity level requires (the money flows through the NIS).

The share of activity-based funding is decided by parliament. Since its introduction in 1997 the share has oscillated from 35% activity-based funding and 65% block grants to 60% activity-based funding and 40% block grants in 2005, and in 2006 the situation was 40% activity-based funding and 60% block grants. The principle is that the activity-based funding element should not cover the full cost. The introduction of activity-based funding is followed by a substantial increase in the number of cases treated and a reduction in waiting times (Hagen and Kaarbøe 2004).

The mental health services are financed by block transfers from the state to the regional health authorities and by earmarked means as part of the Escalation Plan for Mental Health. So far there is no activity-based funding in place for this area, although there are some fee-for-service arrangements established for mental health care services provided as part of ambulatory care.

The activity in ambulatory care is subject to tariff reimbursement (fee-for-service) to the regional health authorities from the NIS and block grants (before

2004 the cash flow went directly to the hospital). The tariffs are upheld in order to promote treatment without hospitalization. The scheme is run by the Ministry of Health and Care Services that set up, for instance, new tariffs, while the payment arrangements and surveillance/auditing are conducted by the NIS (the fee-for-service system for ambulatory care is regulated by directives).

Laboratories and radiology activity are financed in a complex manner. Laboratories/radiology activities owned by the health enterprises are financed according to a set of tariffs, from the NIS to the regional health authorities and block grants. That is, for the same laboratory sample, reimbursement will depend on whether the patient is an inpatient (then the reimbursement is based on block grant/DRG) or outpatient (then the reimbursement is based on fee-for-service from the NIS). Further, private laboratories have a different set of tariffs and are paid directly by the NIS, after agreement with the regional health authorities.

Private health care

Traditionally the patient has to pay the full cost of treatment in private hospitals, but the regional health authorities are allowed to contract with private agencies (some hospitals, specialists and outpatients' clinics) in order to satisfy patient demand. If the Ministry of Health and Care Services gives its approval of the agency, it then reimburses the regional health authorities in the same way as if the patient were treated at a hospital owned by the health enterprise (with activity-based funding). There is no direct money transfer between the Ministry of Health and Care Services and the private agency; the money is channelled through the regional health authorities and then to the private agency according to the terms of their contract. There has been a DRG-points growth for private hospitals from 0.2% of the total DRG points in 1999 to 2.1% in 2003.

Where there is no agreement with a public agency (state or municipality level), the patient has to pay out-of-pocket expenses in full.

Pharmaceuticals

Payment for pharmaceuticals outside institutions is normally subject to out-of-pocket expenses, and reimbursement from the NIS. In Norway, pharmaceuticals are divided in three classes: first, non-prescription pharmaceuticals, subject to 100% co-insurance for the patient; second, prescription pharmaceuticals in the White prescription class, subject to 100% co-insurance for the patient; and third, the Blue prescription class subject to patient subsidy from the NIS. The sales figures under the Blue prescription arrangement are the largest (see section on pharmaceuticals for further details).

Pharmaceuticals in hospitals and nursing homes (institutions) are paid for by the health enterprise and the municipality, respectively.

Paying health care personnel

Norwegian health care personnel are mainly salaried employees. The main exceptions are:

- physician specialists paid by fee-for-service from the NIS, out-of-pocket payments and lump sum grants from the regional health authorities;
- GPs paid by fee-for-service from the NIS, out-of-pocket payments and capitation from the municipalities;
- physiotherapists paid by fee-for-service from the NIS and out-of-pocket payments.
- dentists are usually paid directly by patients without any subsidy from the NIS, but some procedures may be subsidized by the NIS based on fee-for-service tariffs.

The main salary negotiations for public health care professionals are normally set between the state, represented by the State Negotiation Body (NAVO) and the municipalities represented by the Norwegian Association of Local and Regional Authorities (KS) and their counterpart member organizations for the employees such as the Medical Association of Norway, Nurseries Association of Norway and Dentist Association.

Since the hospital reform in 2002, local negotiations became more important (Brenne 2003). Negotiations take place at three levels, which are completed consecutively. First, the 'union of unions' negotiate centrally those issues that affect all employers, for example matters relating to pension funds or insurance. Each union then negotiates centrally on issues only affecting their members. For health staff this stage covers minimum levels of payment for different services. The third step consists of local negotiations, which in the hospital sector now takes place at the health enterprises. The negotiations in 2003 were the first to be completed according to this new model. In summary, health staff members working for state bodies negotiate with the state at one of the above-mentioned three levels. Health personnel working in the municipalities negotiate in the same way.

In 2003, physicians employed by the regional health authorities earned NKr 53 000 per month on average. This included compensation for working overtime and non-regular hours, etc. The average for nurses was NKr 25 000 per month. In comparison, the average monthly salary in 2003 for all employees in Norway was NKr 27 300 (Statistics Norway). However, it must be noted that specialists in hospitals earned around NKr 66 700 per month (or around

NKr 800 000 per year) while GPs earned around NKr 83 300 per month (or around NKr 1 million per year) in 2003.

Regular GPs receive per capita reimbursement from the municipalities based on the number of patients on their lists (around NKr 300 per patient), amounting to approximately 30% of the GP's income. Further reimbursement from the NIS for activity-based on the tariffs (fee-for-service), and out-of-pocket expenditures from the patient, amount to 70%. The income base for GPs is negotiated centrally and is the same throughout the country. Income negotiations for the per capita reimbursement are made between the Norwegian Medical Association and the municipalities' central negotiation body, KS. GP unions and the state negotiate the fee-for-service rates and the patient out-of-pocket payments. GPs in the public GP scheme are obliged to commit to an additional 7.5 hours of municipality services; usually these GPs are paid according to a fixed salary. The physician then receives their salary together with the overtime payment and the municipality keeps the fee-for-service and the patient payments.

Specialists, in agreement with the regional health authorities, are reimbursed from the NIS based on fee-for-service, from patients' out-of-pocket payments and block grants from the regional health authorities. This income base is negotiated centrally and is the same throughout the country. The income negotiations for the fee-for-services and the patients' out-of-pocket payments are negotiated between the Norwegian Medical Association and the Ministry of Health and Care Services. After the hospital reform in 2002, when the responsibility for the specialist health service was transferred away from the counties, specialists with private practices signed contracts with the regional health authorities in order to receive NIS subsidies.

All health personnel employed (including managerial staff, physicians, nurses, pharmacists, etc.) in a health enterprise are normally salaried. However, the local health enterprise is free to set its own salary schemes. There are, for instance, examples of activity-based salaries for physicians. In the 1990s much of the growth in the income for hospital physicians was in areas such as payment for overtime and night shifts rather than in the basic salary (Brenne 2003). Following hospital reform the rates were changed so that the basic salary increased, whereas payments for extra activities were reduced.

Pharmacists are usually salaried, but may have their salary based on sales results.

Complementary or alternative medical practitioners are usually self-employed thereby choosing their own income according to market rates, but these fees are usually set in consultation with their respective member association.

4 Planning and regulation

The main acts on which health services are based, and on which health services function are as follows:

- The Social Security Act adopted in 1991 stipulates conditions for entitlements to social security benefits;
- The Municipalities Health Services Act adopted in 1982 defines the tasks and responsibilities for hospitals and specialized health care services;
- The Specialized Health Services Act adopted in 1999 defines the tasks and responsibilities of the hospitals and specialized services;
- The Health Care Personnel Act adopted in 1999 defines the rights and duties of the 27 authorized groups of health care personnel;
- The Patients' Rights Act adopted in 1999 stipulates the rights and duties of patients in general, and includes citizens' rights to examinations and treatment;
- The Mental Health Care Act adopted in 1999 stipulates the use of restraints in mental hospitals and to the special rights and duties of patients in such hospitals;
- The Communicable Diseases Act adopted in 1994 stipulates protection against communicable diseases;
- The Supervision Act adopted in 1984 outlines the principles of supervision of the health service and health personnel;
- The Act of Patient Compensation adopted in 2001 stipulates the procedure of economic compensation for injured patients;
- The Health Enterprise Act adopted in 2001 defines the regional health authorities and the health enterprises.

Each of the Acts regulates a rather large area of the health system. According to Molven (2002) the use of legislation as a tool to control and deliver health care services has increased recently. Legislation not only defines who is responsible for what, but also to a great degree instructs those who are responsible how they should carry out their responsibility.

4.1 Regulation

At the national level, the political decision-making body is the parliament. The executive body is the Ministry of Health and Care Services. The responsibility of the national bodies is to determine policy, prepare legislation, undertake national budgeting and planning, organize informal channels, and approve institutions and expand capacity. The responsibility for primary health care, including nursing care for the disabled and elderly, is decentralized to the municipalities while the responsibility for specialized health care lies with the regional health authorities. Dental care is part of the counties' responsibility.

The most important law regulating the provision of primary health care is the Municipal Health Services Act of 1982 (which came into force in 1984). According to this act, municipalities have responsibility for the primary health services. They are responsible for planning and developing primary health care services to meet the needs of the residents. Planning responsibility also includes health services provided by other providers, such as making agreements with the regular GPs or private nursing homes. The municipalities are self-governed by local politicians in cooperation with local civil servants, and are free to set up their own local management models.

According to the Dental Care Act of 1983 (which came into force in 1984) county councils are responsible for public dental care (in practice most of these services are conducted for people under the age of 18).

The Health Enterprise Act of 2001 (which came into force in 2002), relates mainly to the tasks and responsibility of the hospitals and specialized services. The health enterprises are separate legal entities and are thus not an integral part of the central government administration. Fundamental health laws and regulations, policy objectives and frameworks are, however, determined by central government and form the basis for the management of the enterprises. The organization of the enterprises stipulates in several ways how the owner may exercise control. First, central government appoints the regional board members. In the period 2002–2005 no politicians were among the members of the boards. The only groups with formal representation were employees of the enterprises. As of 2006 local politicians become board members. Second, the

owner exercises control as outlined by the Health Enterprise Act, through the articles of association, steering documents (contracts), and through decisions adopted by the enterprise meeting. The ministry has attempted to separate a formal steering dialogue from the more informal arenas of discussion (Opedal and Stigen 2002). Third, the state finances most of the hospital activities, and there is also, of course, a formal assessment and monitoring system – with formal reports on finances and activities submitted to the ministry. On one hand, hospitals are part of a command and control system hierarchy, since the state owns them and can instruct them directly. On the other hand, the hospitals have gained more autonomy since professionals replaced county politicians, and the hospital structure today more closely resembles a corporation than a public administration body.

The Mental Health Care Act stipulates that psychiatric treatment and services are, from an organizational and administrative point of view, part of the specialized health services. However, certain aspects of mental health services (for instance coercive/mandatory treatment) are regulated by the Mental Health Act. The main objective of this act is to ensure that mental health care, both voluntary and coercive, is carried through in a proper fashion and in accordance with existing rules and regulations that relate to civil rights. This law emphasizes the principle of human rights in connection with patients undergoing treatment, and underlines the importance of promoting voluntary treatment, rather than coercion, wherever possible, thereby emphasizing the importance of the patient's autonomy and right to choose for him/herself.

The Norwegian Medicines Agency is the national, regulatory authority for new and existing medicines, and the supply chain. The agency is responsible for supervising the production, trials and marketing and final approval of medicines. It monitors and ensures cost-efficient, effective and well-documented use of those medicines. The agency also supervises the supply chain, and regulates prices and trade conditions for pharmacies.

The Directorate for Health and Social Affairs is the administrative authority responsible for health and social legislation. The directorate manages and interprets health and social legislation on behalf of the ministries as provided in the regulations.

The Office of the Auditor General plays an important regulatory role for the national politicians. This office is the Norwegian supreme audit institution and the supervisory body of the Norwegian Parliament and has the status of an agency that is independent of the Norwegian Government and public administration. The main task of the Office of the Auditor General is to ensure that public assets are used and administered according to sound financial principles and in keeping with the decisions and intentions of parliament.

Regulation and governance of third-party payers

Most of the health care services in Norway are publicly funded, but third-party payers also play important role. The main sources are from the National Insurance Administration (fee-for-service) and from the Ministry of Health and Care Services (activity-based funding).

The municipalities and the regional health authorities (and also in some instances the Ministry of Health and Care Services) regulate the private health sector by approving private agencies for public funding (activity-based funding and fee-for-service funding). They cannot prevent practitioners from establishing a private practice. Their regulatory power is restricted to controlling the public financing of private practitioners.

The National Insurance Administration is formally accountable to the Ministry of Labour and Social Inclusion, part of the central administration, and is, therefore, under the direct control of the same mechanism as other central government bodies. This means that the ministry has direct control over the National Insurance Administration, and therefore exercises the same controls and budget control as other central public bodies. The National Insurance Administration is funded in the national yearly state budget, which is passed each year by the Norwegian Parliament. The National Insurance Administration audits, as a third-party payer, the reimbursement process to the providers (mostly regular GPs, specialists, ambulatory care services, individual cases, etc). The Ministry of Health and Care Services is auditing the activity-based funding process.

Regulation and governance of the third-party payments comes under the control of central government and is included in the national budget. However, as with any public body, payments can be audited by the Office of the Auditor General, the Norwegian Supreme Audit Institution and the supervisory body of the Norwegian Parliament, which has independent status from the Norwegian Government and public administration.

Regulation and governance of providers

The health care system is mostly publicly owned, though there are some contracts with private agencies, mainly between municipalities and GPs, and between health regions and specialists. The GPs' financing model is approved at the national level, thereby allowing little room for municipalities' freedom in the reimbursement of GPs (see section 3).

The state plays a stewardship role in relation to providers at national, regional and district levels. There are four main legal regulatory tools for health care services: laws, directives, circular letters and advice letters. Parliament

passes the laws, while the directives, circular letters and advice letters are the responsibilities of government. The Ministry of Health and Care Services plays a stewardship role for the five health enterprise regions, even though these enterprises are separate legal subjects and governed by independent boards. The Ministry of Health and Care Services provides instructions to the regional health authorities through a “letter of instruction”, which is prepared individually for each of the five regional health authorities and can be seen as a “government supplement”. There have also been instances where the Ministry of Health and Care Services has reviewed decisions made by the health enterprises. While the ministry has a monopoly with regard to health enterprises (specialist care), the governance of the municipalities relating to primary health is in practice an interplay between a number of different ministries, such as the Ministry of Health and Care Services, the Ministry of Labour and Social Inclusion and the Ministry of Local Government and Regional Development.

The central level is responsible for a large range of activities related to health services, such as stewardship, inspection, quality control of clinical activity, education and research. Legislation does not regulate the organization of the public central administration. The government is entitled to create the most suitable government platform. Parliament votes for alterations in budget/expenses or amendments during budget and amendments resolutions. In addition, parliament can influence the government through parliamentary control.

The Norwegian Registration Authority for Health Personnel was established in 2001 and took over all the licensing and approval of health care personnel. In 2002, the authority was placed under the control of the Norwegian Directorate for Health and Social Affairs.

The responsibilities of the Norwegian Board of Health are stipulated in numerous laws and directives, central to which is the Health Services Supervision Act of 1984. This law authorizes the inspection of all areas of the health care system, including health care personnel, and it defines the roles of the Board of Health and the county physicians with regard to these inspections. The responsibilities of the Board of Health regarding the surveillance of health and social affairs services include gathering information about the structure and functions of the services, writing auditing and evaluation reports based on inspections from the county physicians etc, transferring information to the directorate and department (basic knowledge and experiences) and developing proposals for advice and guidance in maintaining professional quality standards and norms. The Board of Health is a competence centre for methodical supervision, and it also controls health care personnel in terms of compliance. As of 2003 the county physicians are responsible to the county governor’s office. The county physicians carry out health inspections for the Board of Health in

each county. The County physicians are responsible to the Board of Health when carrying out inspections according to the law. Administratively they belong to the County Governors' office, subject to the Ministry of Government Administration and Reform (Fornyings- og administrasjonsdepartementet).

Regulation and governance of the purchasing process

In the Norwegian health system, contracting mostly occurs between the municipalities and the GPs, and between the regional health authorities and private agencies (such as laboratories, radiology services, private specialists and private hospitals). A White Paper (St.meld. nr 5, 2003–2004) reported that there are limited conditions for sound competition in the Norwegian health system with regard to specialist health care. However, most private agencies in the specialist health care field have incentives to make contracts with the regional health authorities since contracting brings reimbursements from the NIS. This is also the case with regard to the GPs and the municipalities.

As regards private agencies, the state may be both the purchaser and the supplier of hospital services, and this situation may lead to the suspicion that the private agencies are treated unfairly since the state owns the hospitals. This anomaly in the purchaser/provider role in the hospital model has been criticized by the OECD (Byrkjeflot and Grønlie 2004). In 2005 the Ministry of Health and Care Services tried to regulate the dual role of the purchaser/provider, stating that the regional health authorities must be clearer about their role as “caring for” health services and as owner of their own health enterprises in relation to private agencies.

As part of the European Economic Agreement, Norwegian private and public bodies/organization follow the tendering rules (anbudsregler) adopted in the EU. These rules also apply to some health care services.

4.2 Planning and health information management

Health technology assessment

On 1 January 2004 the Norwegian Centre for Health Technology Assessment (SMM) merged with the Foundation for Health Services Research (HELTEF) and the Division of Knowledge Management at the Norwegian Directorate for Health and Social Affairs, to form the Norwegian Knowledge Centre for

Health Services. The reason for this merger, according to the government, was to strengthen the decision base for the Ministry of Health and Care Services by creating a stronger organization model.

The centre is organized under the Directorate for Health and Social Affairs but is scientifically and professionally independent. The centre has neither the authority nor the responsibility to develop or implement health policies. The centre disseminates evidence about the effects and quality of methods and interventions within all parts of the health services. The uptake of this evidence by the health services is also an important goal for the centre's activities.

Among its central tasks are:

- Health technology assessment reports, systematic reviews, overviews of overviews and early warnings;
- projects that aim to improve the quality of patient information;
- surveys of patients' and employees' experiences with health services;
- support to the health services of poor countries through the provision of evidence about the effect of relevant health interventions;
- support to the government, the regional health authorities, and the health services in general to incorporate evidence into their practice.

The Directorate for Health and Social Affairs is working on establishing a proper framework for the development and maintenance of medical guidelines. Until recently, there was no central national policy on medical guidelines.

Information systems

At the national level there are registers covering different aspects of the health of Norwegian citizens. These registers cover the entire Norwegian population and include data for several decades. There are several medical databases containing information about health outcomes and other information related to specific treatment or diagnoses, which are used in order to assess the effects of different treatments or institutions upon patients' health in primary and specialized health care. These databases have been set up by initiatives from individuals, hospitals or educational institutions, and they provide valuable information for assessing the effects of different treatments and benchmarking production units down to ward level. The registers contain sensitive information about patients, and are, therefore, monitored by the Data Inspectorate. The Personal Health Data Filing System Act entered into effect on 1 January 2002.

The Norwegian Institute of Public Health bears the responsibility for ensuring good utilization, high quality and simple access to the data in the registers, as well as assuring that health information is treated in accordance with the rules for

basic protection of privacy. Seven central health registers have been established in accordance with the Personal Health Data Filing System Act:

- Cause of Death Register
- Norwegian Cancer Register
- Medical Birth Register of Norway
- Norwegian Surveillance System for Communicable Diseases (MSIS)
- Tuberculosis Register
- Childhood Vaccination Register (SYSVAK)
- Norwegian Prescription Database.

With the exception of the Cancer Registry, responsibility for these registers lies with the Norwegian Institute of Public Health.

Statistics Norway has been responsible for gathering the relevant statistics for the Cause of Death Register since 1922. This register receives notifications of deaths and is in charge of data processing and producing the official statistics on causes of death. Approximately 50 000 notifications of death are received annually, which must be codified according to international classificatory systems and further adapted for statistical purposes. Statistics Norway still runs the Cause of Death Register and has an agreement of cooperation with the Norwegian Institute of Public Health.

The Cancer Registry of Norway is a governmental institute for population-based cancer research based at the Rikshospitalet – Radiumhospitalet HF (a public-owned health enterprise situated in Oslo). The Registry has recorded cancer cases nationwide since 1953. A computerized population registry combined with the matching of information from several sources, have resulted in accurate and complete cancer registration. This information is used in research projects to further knowledge about the causes of cancer, its development and diagnosis, and the effects of treatment. In addition to research, the Cancer Registry is also involved in a number of screening projects, clinical monitoring and genetics in relation to cancer. An important part of the Cancer Registry's activities is to make facts regarding the cancer incidence and its changes available over time.

The Medical Birth Registry of Norway is a national health register of all newborns, which aims to provide research and surveillance of health conditions in relation to pregnancy and birth. The register is held by the Norwegian Institute of Public Health and is run by the University of Bergen.

MSIS is Norway's official monitoring system for infectious diseases. Notifications from microbiological laboratories, hospitals and physicians concerning new cases of infectious diseases are collected on a database at the

Norwegian Institute of Public Health. Statistics from MSIS are easily available on the web.

The Tuberculosis Registry was established in 1962 and it is a national register for collecting information about the incidence and prevalence of tuberculosis.

The Childhood Vaccination Register (SYSVAK) was developed to monitor child vaccination coverage in Norway. It contributes to ensuring that all children are offered the appropriate vaccines. Community nurses are obliged to register all children's vaccines in the central register.

The Norwegian Prescription Database is a national health register containing information about the distribution of pharmaceuticals from pharmacies in Norway. The database is used for pharmaco-epidemiological research and pharmaceutical statistics.

There are other bodies in system that gather and provide information. The Norwegian Patient Register collects the information that each hospital registers for their patients, which includes information on age, gender, duration of stay and DRG-coded diagnosis. The register also contains patient data from psychiatric institutions for adults. This register is a vital source of information about patients and activities in hospitals. At present, the NPR data are anonymous, but the government (Soria Moria erklæringen) wants these data to be non-anonymous. The patient's name will still be anonymous, but it will be possible to track the same patient at different levels in the health care system, whereas at present the data only register occurrences.¹⁰ (In short, we know that there are around 3.5 million ambulatory cases, but we do not know how many people this figure represents).

Statistics Norway is the central body responsible for collecting, analysing and disseminating official statistics. According to the Statistics Act of 1989, Statistics Norway has the power to decide what should be contained in the official statistics and is responsible for organizing all of the official statistics in Norway. Statistics Norway's role as an autonomous producer of statistics, as laid down in the Act, is particularly important where use of the statistics is dependent on trust. The bodies involved in managing information on health services activity and health status provide vital information to central, local and regional authorities, other public authorities, researchers, media and the public.

¹⁰ At the time of writing, the heralded legislation regarding NPR had not passed the Parliament.

Research and development

The total amount of money spent on research and development in Norway was 1.7% of the GDP in 2003, an average of 2.2% for OECD countries (Norges forskningsråd, 2003). According to the Global Forum for Health Research in 2004, Norway's health research and development (R&D) as a percentage of GDP is 0.18 or approximately 10% of the total R&D expenses in 2003. The Health Research and Development as a percentage of total health expenditure has been approximately 2%.

The Barcelona statement of EU countries states that 3% of the GDP level should be devoted to research and development as a long-term political goal. Norway is, therefore, considerably behind comparable countries as regards general research funding. Norway also spends less money on clinical and health research in comparison with other countries, including the Nordic countries.

The Research Council of Norway, a government agency under the Ministry of Education and Research, has an annual budget of more than Nkr 4 billion and plays a central role in Norwegian research. The mandate of the Council is to promote and support basic and applied research in all areas of science, technology, medicine and the humanities. For 2005 the research council of Norway's budget on medicine was Nkr 142 million.

The main settings for Norwegian research are universities, the clinical sector (hospitals) and the research institute sector. All these sectors are organized, steered and financed differently and, therefore, have their own working culture and incentives. In 2004, a grant for research, education and national medicine competence centres was established giving the regional health authorities a greater responsibility for research (in 2004, this was around Nkr 1 billion). The regional health authorities receive the grant from the state based on the degree of research activity, which thereby gives them an incentive to secure research and the build-up of competence centres. In the budget for 2006 this research grant was approximately Nkr 400 million.

Norway is known worldwide for creating large and important population-based databases for epidemiology (Joint Committee report, 2004). International research in this field has been and is still at the forefront, particularly in the areas of cardiovascular diseases and perinatal conditions but also more generally in the use of biobank materials in epidemiology. Recent legal changes have made it possible to use the many individual-based health-related registers for research purposes – including linkage to surveys based on the personal identification numbers of citizens. Norway, together with other Nordic countries is, therefore, able to conduct advanced research and contribute to international cooperation utilizing these unique data.

One of these epidemiology studies is the HUNT study. The Nord-Trøndelag health study, HUNT, is one of the largest health studies ever performed, and comprises a unique database of personal and family medical histories, collected in two intensive studies. HUNT 1 was carried out in 1984–1986 in order to establish the health history of 75 000 persons. HUNT 2 was carried out to study the evolution of the health history of 74 000 persons during 1995–1997, and included blood samples collected from 65 000 persons organized in a biobank database containing genetic information. About 75% of the population in Nord-Trøndelag County participated in the HUNT study during these two periods. HUNT today is an integrated family and personal database of 103 000 persons, all common to the national health registries. Repeated examinations and follow-up of the same population make it possible to ascertain changes in the health and vital status at individual and family levels. The HUNT study is reinforced and supplemented by: the development of cross-referenced registries at regional level, such as the registries on radial and hip fractures, venous thrombosis, lung embolism, ischemic heart disease and stroke; and developments of cross-referenced registries at national level, such as the Cancer Register, the Medical Birth Register, and the National Health Insurance Register. Additionally, Statistics Norway is providing the Population Census Register and the Family Register, making a genealogical database (family trees).

The purpose of the Norwegian Mother and Child Cohort Study (data collection started in 1999) is to detect the causes of serious diseases among mothers and children. Approximately 100 subprojects with specific research questions have been suggested. These questions are mainly related to environmental factors such as medication, nutrition, infections and work exposure. Genetic factors as well as the interplay between genes and the environment will be studied. Blood samples from the maximum number of fathers possible will also be collected, enabling associated studies between genes and diseases.

Despite the achievements in health sector research, some challenges still exist in Norway. The Joint Committee Report (2004), appointed by the Research Council of Norway, argued that a number of fundamental structural problems exist that need to be recognized and dealt with so that research could be developed to its full potential. The main problems, which are only briefly summarized here, are perceived to be the following:

- low funding for clinical and health research
- an inadequate infrastructure with limited access to specialist support and/or equipment
- a lack of coordinated and interdisciplinary research
- insufficient international collaboration

- too many small research units
- weak scientific leadership
- inadequate international publication.

A White Paper (St.meld nr 20, 2004–2005) states the government's wishes for research and development in general. Medical science is one of the four priorities in this White Paper, the ambitions being to strengthen the infrastructure and availability of data from the health registers and biobanks. The conditions for clinical science should be improved, as this will lead generally to better patient treatment. It also points to the fact that more research needs to be done in the field of health services, such as health economics and organization, in order to create an efficient health care system. Furthermore, Norway should continue to strengthen its engagement in the global field. As a response to the relatively low percentage of GDP spent on research and development, the government intends to increase the spending to 3% of the GDP by 2010.

5 Physical and human resources

5.1 Physical resources

Infrastructure

The overall responsibility for the planning of infrastructure and capital investments in the Norwegian health care system lies in the public sector. It is true to say that, with state ownership of the hospitals and national escalation plans (e.g. escalation plan for mental health care), the state is the most active sector of the infrastructure with regard to build-up and capital investments.

Planning and distribution of infrastructure

The 1980s and 1990s saw a decrease in the number of beds in somatic hospitals. The apparent increase in more recent years is due to the fact that private rehabilitation institutions are included in the statistics from 2000. Looking only at somatic hospitals, it can be seen that there has been a reduction of about 2000 beds from 1990 to 2003, or around 10–12%. At the same time there was an increase in ambulatory care (from approximately 2.5 million consultations in 1990 to 3.5 millions consultations in 2003). While the number of beds has been relatively stable, there has been a decrease in the average length of stay. In 1990, this averaged at 7.2 days while in 2004 it was reduced to 5.2 days.

The numbers of inpatients and residents in mental health institutions are reduced considerably (see Table 5.1). The decrease has occurred mostly in psychiatric hospitals. Developments during the 1990s included the downsizing of mental health institutions for adults, which was associated with the decrease in the number of inpatient stays and an increase in ambulatory activity. As part of the escalation plan for mental health care there has been a build-up

of community mental health centres (Distriktpsykiatriske sentre, DPS). The capacity for ambulatory care has increased with regard to mental health (from around 0.4 million in 1990 to 1.05 million consultations in 2004). Mentally-ill people have, to a great extent, left institutional care to live in the community. There has also been a decrease in institutional beds for the mentally retarded as part of HVPU-reform at the end of the 1980s.

The number of beds in long-term institutions has remained relatively stable since the 1980s. However, the greatest change in this area has been in the construction of single-bed care facilities (currently around 90% of the beds) in nursing homes and in the construction of sheltered houses (pleie- og omsorgsboliger). This construction was part of the action plan for the elderly and was followed by earmarked means to the municipalities.

Capital stock and investments

The essential difference between capital investments in hospitals and primary care facilities is that the central government owns hospitals, while the primary health care facilities are the municipalities' responsibility. There are two main laws on accounting: the account law (regnskapsloven) applies to the health enterprises while the cash-per-law (kontantprinsippet) applies to the municipalities.

Regional health authorities and the health enterprises

As explained earlier, the country was divided into five health regions in 2002. Each of them has been given wide authority to plan and manage the infrastructure in each of their regions. Following accrual accounting principles, the health enterprises are expected to cover the annual depreciation costs within their annual budgets/funds. The income and capital distribution are historically conditional. The government suggests a certain allocation of these resources, with a 50–50 distribution basis in accordance with the present distribution between the health regions and objective criteria. Through the health enterprises' provider responsibility, they are required to provide the population with proper health services by contracting with private providers for the appropriate services. These agreements must take into account the private providers' need for capital investments.

Investments are funded by health enterprises from basic grants, which cover depreciation costs, and admission to debt finance. A few large development projects are eligible for special investment grants. Borrowing for investment purposes in the regional health authorities is organized through the public bodies, administered by the Ministry of Health and Care Services. The regional

health authorities are not allowed to borrow money from the private market. The steering system for investments in the regional health authorities consists of the authorities to the health enterprises and supervision to secure that investments are in accordance with national health political goals and within acceptable economic frameworks. As the owner, the Ministry of Health and Care Services shares responsibility for follow up and control of investments in the health enterprises. In addition, the ministry has the authority to approve larger building projects in accordance with specified regulations.

Municipalities

The state's block grant transfer to the municipalities is their principal source of finance, and is based on a distribution formula that takes into account the number of inhabitants, demographic structure and other factors. This block transfer also finances the municipalities' health care responsibility, but is, nevertheless, freely distributed according to the municipalities' priorities. The Local Government Act section 59a outlines the rules about state accounting, auditing and approval of financial obligations.

Although primary health care is financed from the block grant, the municipalities may borrow money to finance buildings, construction and properties for their own use. Borrowing must be done in the private sector, the block transfer must then handle the interest and repayments, but there are rules determining the financial framework for borrowing.

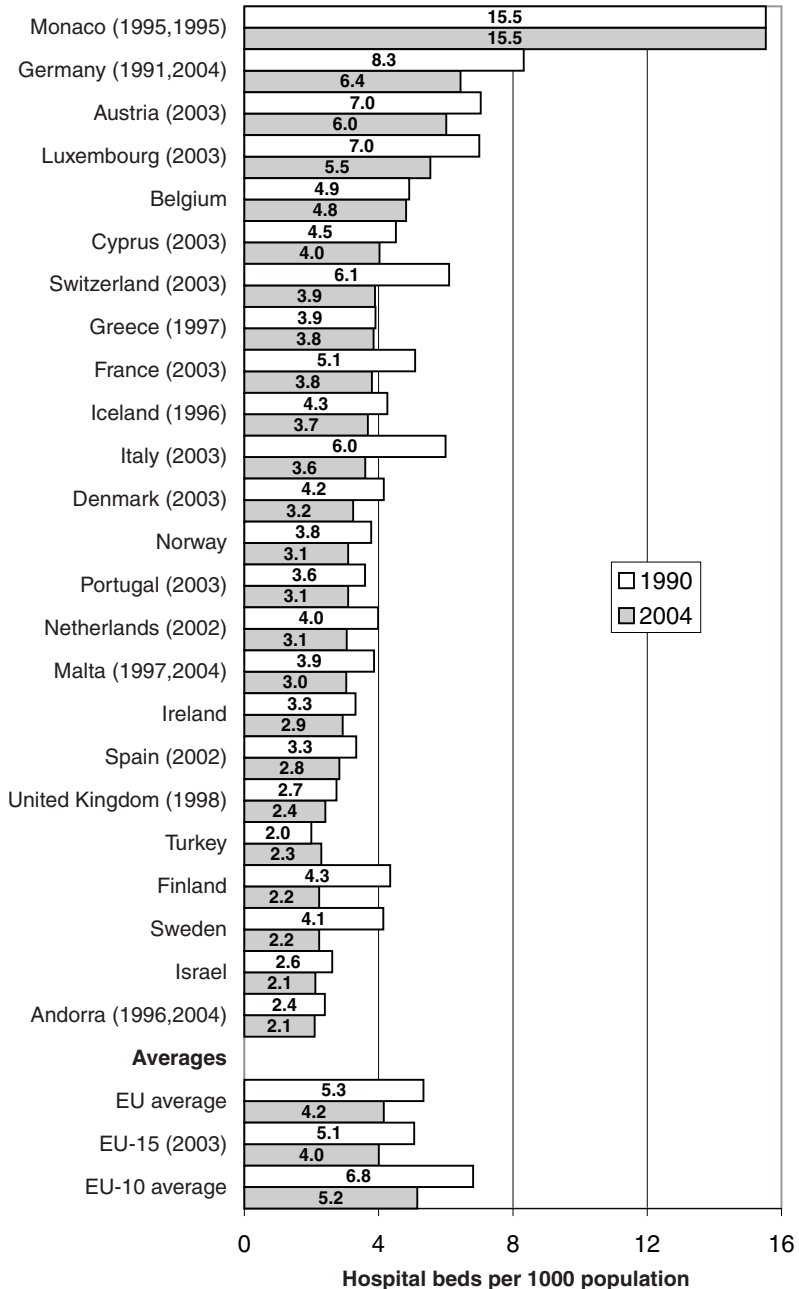
Earmarked transfers can also be made from the state to the municipalities, and, for instance, were given as part of the action plan for the elderly (1998–2001) to build and modernize nursing care facilities, and are seen today as part of the escalation plan for mental health.

Table 5.1 Acute care and psychiatric hospitals and long-term institutions, 1980–2004, selected years

	1980	1985	1990	1995	1997	1998	1999	2000	2001	2002	2003	2004
Acute care												
hospital beds	22 687	20 812	17 176	15 300	14 992	14 943	14 711	16 442	16 723	16 911	17 141	17 096
Psychiatric												
hospital beds	12 261	9 921	8 011	6 667	6 368	6 290	9 155	6 091	5 821	5 751	5 633	5 500
Long-term												
hospital beds	–	45 607	45 628	43 928	43 377	43 196	43 240	42 876	42 741	42 319	41 718	41 402

Source: Statistics Norway, 2004.

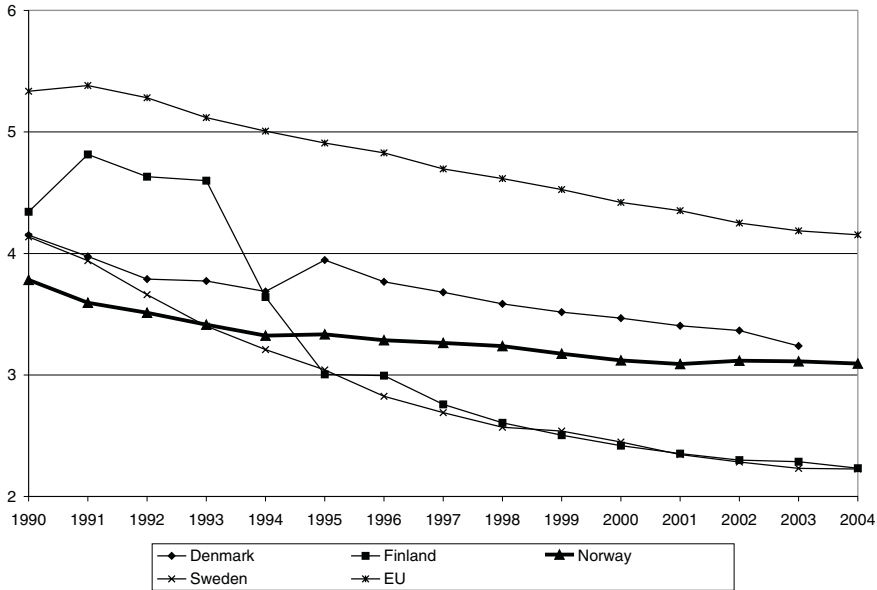
Fig. 5.1 Hospital beds in acute hospitals per 1000 population in western Europe, 1990 and 2004 or latest available year (in parentheses)



Source: European Health for All database, January 2006.

Note: EU: European Union; EU-15: Member States before 1 May 2004; EU-10: Member States joining the EU 1 May 2004; countries without data not included.

Fig. 5.2 Beds in acute hospitals per 1000 population in Norway and selected countries, 1990–2004



Source: European Health for All database, January 2006.

Information technology

According to Gallup Intertrack, in October 2003, 2 849 000 (76%) persons over the age of 13 (from a total of 3 763 000) had access to the Internet in Norway. Of these, 2 502 000 had used the Internet the last thirteen days. Some 1 675 000 people use the Internet on a daily base, with 1 265 000 households (total households: 1 961 548) having access to the Internet. Some 1 588 000 people had access to Internet in the workplace. There are differences in Internet use according to age and education. Younger people, especially 13 to 19-year-olds, use the Internet most, followed by those aged 20–39, 40–59 and 60+. There are variations in Internet use among different educational groups. People with a university education use the Internet far more than those who have only elementary education. Internet usage in Norway is among the highest in the world.

The National Health Network has been established recently and now entails security and capacity mechanisms that are required in order to exchange information in the health and social sectors. This is the first step in establishing cooperation between administrative levels and across regional borders. The vision is for the National Health Network to contribute to high-quality and

coherent health and social services, by being a sector network for effective cooperation between the different services. The National Health Network aims to support the exchange of information and to provide affiliated organizations with professional support, medical services and administrative services. This opens up new possibilities with regard to the division of functions, specialization, cooperation when making duty lists and professional cooperation. A basic principle of the National Health Network is that there should be one point of communication that can provide access to a broad range of services and an electronic exchange of information. Such services should, among other things, include secure e-mail and exchange of electronic messages, telemedicine services, use of common systems on the network and controlled access to the Internet. Users should be able to communicate with all the other players that are connected to the network from this single communication point. Currently, all public hospitals are connected to the National Health Network. In two of the health regions almost all GPs are connected in this way, and work is underway to include GPs in the rest of the country. Further work is being carried out in order to connect, for instance, pharmacists and nursing care facilities.

All GPs use electronic patient records (EPRs) today. In general, the health enterprises (and the nursing homes) have not come as far as the GPs in introducing EPR. This is mainly because of the special challenges associated with introducing an integrated EPR system into complex organizations. Integration between clinical systems, laboratory systems and administrative systems today is often poor. The transition from paper patient records to electronic applications is often not complete. The result is that most health enterprises have some kind of hybrid application in which paper patient records still exist, with electronic applications containing only some of the information elements that form part of the complete patient record.

The use of telemedicine in Norway is not widespread. The country's geography makes this topic very relevant, and it is currently on test conditions in some areas. At the academic level, telemedicine is situated at the Norwegian Centre for Telemedicine at the University hospital in Tromsø. The Norwegian Centre for Telemedicine was designated as the first WHO Collaborating Centre for Telemedicine in July 2002.

In order for the patients to make the hospital choice task easier, the state set up an Internet site (www.sykehusvalg.net) in 2003 where patients can find information about hospitals, waiting times, quality indicators, kinds of treatment, etc. It is also possible to call a "green number" for information (free of charge).

The proportion of Norwegians who use the Internet for health purposes increased from 19% in 2000 to 31% in 2001 (Andreassen et al 2002). The

proportion of those wishing to use e-mail in interaction with their physician increased from 30% to 45%. Based on information from the Internet, 33% of users in 2001 asked their physician specific questions, 11% suggested a diagnosis, 21% altered their diet and/or lifestyle; 10% started using health products or embarked on programmes without consulting their physician, 13% experienced anxiety, while 48% experienced relief. These findings imply that Norwegians' use of the Internet is supplementing rather than replacing the ordinary health services. However, health personnel will need to respond to Internet-generated expectations and behaviour (Andreassen et al 2002).

The goal of the government strategy S@mspill 2007 (English name: Te@ mwork 2007), is to expand the use of the National Health Network, and to include more participants in the network. The primary aim is for this strategy to contribute to improved teamwork between municipal health and social services, specialist health care and general practitioner services.

Medical equipment, devices and aids

Until 1 January 2002, all public hospitals were owned and operated by the counties. Each county received government funds estimated according to the number of hospitals in the region, and other criteria, such as the size of population. Major purchases of medical equipment were conducted through the public tenders, by the county health office. Other smaller purchases were left to each hospital. Cooperation between the counties on these matters was voluntary. This made it difficult to establish a common procurement policy. To make these procurements more cost and labour efficient, the regional health authorities decided to establish one central purchasing unit in 2003.

The result of this combined effort is the Health Equipment Procurement Service. The unit is a separate legal entity established as an unlisted limited (AS) company, according to Norwegian law. The company is owned by the regional health authorities. The services provided by the company are only open to health enterprises. Privately owned hospitals and health care units operated by local municipalities may not utilize the services provided. The company initially has two functions, the first of which is to act as an adviser. The company assists various health enterprises, both regional and local, with questions relating to rules and regulations, logistics, statistics and in the implementation of modern purchasing tools such as e-trade systems. Secondly, the company plays an active role in the procurement process. It is responsible for nationwide tender invitations; it assists in the selection of tenders and develops framework agreements based on the result of these tenders. The objective is to negotiate more economically advantageous contracts than each enterprise

would achieve on their own, and thus provide a financial gain for all health enterprises in Norway.

A common procurement policy, however, is not applied to all purchases. Only those that are large enough, in both sum and volume, to represent a possible gain, if conducted on national bases, are included. The company has already succeeded in implementing a common nomenclature within this part of the public health care system, namely the UNSPSC. The UNSPSC is a coding system developed by the United Nations to make the identification of generic articles easier. This will make the tendering process less complicated both for the contracting authority as well as for potential suppliers.

However, regarding 'big-ticket' technologies, decisions may be taken by the parliament. For example, the procurement, location and funding of one PET-machine in 2004 was decided by the parliament.

Pharmaceuticals

The process of procuring pharmaceuticals is as follows. The pharmaceuticals are divided in prescription drugs and non-prescription drugs (over-the-counter drugs). In order to obtain a prescription drug a patient must obtain a prescription from the physician, and then present it for dispensing at a pharmacy or a drug outlet. It is possible to buy non-prescription pharmaceutical directly from the pharmacist or, in the case of some items, at a grocery store, according to regulations adopted in October 2003. Three chains control the wholesalers and dominate the pharmacy outlets. However, there is a small proportion of private independent pharmacists, as well as the public area of the market, that is, the hospital pharmacies owned by the health enterprises.

One of the duties of the Norwegian Medicines Agency, represented by its Department of Pharmacoeconomics, is to prepare recommendations and, where relevant, pass resolutions concerning acceptance of drugs to the reimbursement scheme (known as "blue prescription reimbursement" blåreseptordningen). If the companies apply for reimbursement of the new drug, the application is assessed and decided upon by the Norwegian Medicines Agency. Cost-effectiveness considerations play an important role in this assessment. The purpose of the pharmacoeconomic analyses in this context is primarily to identify the *relation* between changes in cost and health outcomes associated with treatment with the drug in question, compared with already existing treatment programmes. If reimbursement of a new pharmaceutical product is associated with a substantial cost increase, this has to be handled by the Norwegian Ministry of Health and Care Services and parliament through prioritization decisions in the yearly budget process.

A price and profit scheme operates for prescription drugs. Prices are regulated according to EEA rules and the pharmacies' margins are set by parliament. Non-prescription (over-the-counter) drugs are not subject to price or profit regulation. From January 2005 a specific price regulation system for generics (step-price system) was introduced, with the intention of lowering prices and increasing the use of generics. The generic price is set as a percentage of the branded price through this scheme. The branded price is normally reduced by 30% when a generic substitute is available in the market. This price was reduced by 40% six months later and by 50% twelve months later. The percentages are higher for pharmaceuticals with a market share of more than NKr 100 million per year.

Direct-to-consumer advertising of prescription drugs is not allowed in Norway, but there are clear indications that the pharmaceutical industry uses the media actively to market their drugs (Hjortdahl and Høyve 2002). This ban does not include media areas that are intended for health professional personnel, for instance professional journals and magazines. Consumer-targeted advertising is allowed in the case of non-prescription drugs, with one exception, TV advertising.

Procurement of pharmaceuticals via mail-order/Internet is currently not allowed.

5.2 Human resources

The area of human resources is an important capital in the Norwegian modern health care system. Health and care service is work intensive, amounting to 215 000 man years, and comprises approximately 17% of the total Norwegian workforce. Compared to other OECD countries, Norway has a high number of health care personnel. In 2002 the density of practising physicians in Norway was 3.4 per 1000 population. Physician coverage has been improving in the last 4–5 years, and nurse coverage is the second highest in Europe after Finland (Fig. 5.4 and Fig. 5.5). Norway has, as other Nordic countries, one of the best coverage of dentists in Europe. The main challenges regarding dental services are the geographical distribution of dentists and their recruitment to public positions.

Table 5.2 Total personnel in the health and social service industry. Education, 2004

Occupations	Number
Physicians	15 281
Psychologists	3 019
Dentists	3 402
Others with university health education	840
Personnel with university health education, total	22 542
Child welfare officers	4 398
Medical laboratory technologists	3 980
Occupational therapists	2 116
Physiotherapists	7 008
Midwives	2 269
Radiographers	1 937
Social care workers	6 027
Nurses	67 294
Dental hygienists	738
Social educators	6 772
Other with university education, lower degree	1 464
Personnel with university education (lower degree, less than 4 years), total	104 003
Auxiliary nurses	55 943
Care workers	11 198
Medical secretaries	5 300
Other with high school education	10 331
Personnel with high school education, total	82 772
Personnel without health education	137 179
Total personnel in health and social industry	346 496

Source: Statistics Norway, Health care personnel, 2004.

Trends in health care personnel

It is estimated that during the 2000s every year will see approximately 4000 more health and care personnel with university degrees on the job market than during the 1990s. Following the adoption of action plans to educate more physicians and nurses, the demand will probably be sustainable, while the undersupply of auxiliary nurses and dentists will increase. The action plan “Right person on the right spot” (Rett person på rett plass) 1998–2001 has resulted in an increase of 12% in the total number of health and social care workers in the period 1998–2001. This increase was sufficient to sustain the goals in the action plans for the elderly and mental health patients.

From 2000 to 2002 there was an increase in the number of nurses in both municipalities and hospitals: 658 and 1617 nurse man years respectively. This reflects a yearly growth of about 2.5% which is below the target figures outlined in the recruitment plan, since a yearly growth of less than 2% is insufficient to address the demand of municipalities. During this period, 3400–4100 candidates were examined and most of them started working in the health care sector. According to Helsemod (a statistics tool), there seems to be a balance between demand and supply in the country, but hospitals need to reduce their demand for nurses if the demand for nurses in the municipalities are to be addressed. Statistics show significant differences in recruitment and coverage of nurses between the counties from 2000 to 2002. The average age for public health nurses is high (due to the post-war baby boom, a common challenge in many disciplines in Norway), and municipalities report a decline in recruitment. The county medical officers will analyse the situation and the Directorate for Health and Social Affairs is planning initiatives to increase the education of public health nurses and thus prevent a shortage. Projections from Statistics Norway on future supply and demand for health personnel show that it is with auxiliary nurses that the future gap between supply and demand is expected to be at its highest. The recruitment plan for health care personnel for the period 2003–2006 focuses mainly on education and competence development as means of addressing this issue. If the projections from the Helsemod project are correct, in the future, it may be necessary for the Norwegian health and social sectors to recruit a large number of auxiliary nurses from abroad.

There were attempts to regulate the supply of physicians from the end of the 1980s in Norway. However, during the 1990s this regulation was ignored by hospitals and many positions were occupied without official approval. Between 1994 and 1999, the number of physicians' positions in specialist health care increased by 50% from 6000 to 9000 a year. At the same time problems with unoccupied positions in the municipalities increased, especially in rural areas in the northern and western parts of Norway.

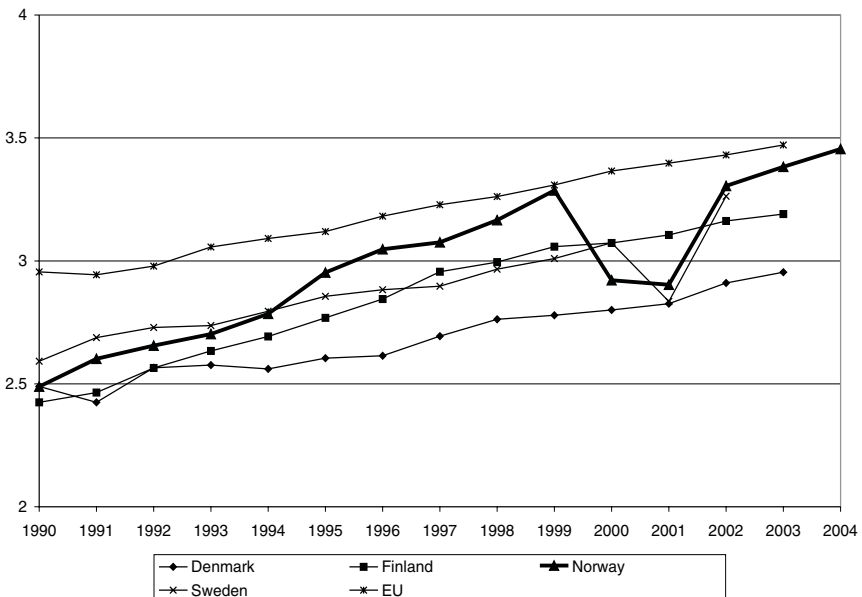
In 1999 the regulatory system for physicians was changed from a contract to a statutory system. The ministry can with this act decide the frameworks for establishing new physicians' positions. With this act the increase in the supply of physicians was transferred from the hospitals to the municipalities. The yearly growth was reduced by 700 man years in 1998 to 100 man years in 2000, while the growth in the municipalities has increased from 50 in the period 1998–1999 to 300 in 2000. There were applicants to all regular GPs' positions in 2002 during the introduction of the RGP scheme. Viewed against this background it is expected that the supply of physicians in the municipalities will be stable in future years. During 2003, 26 new regular GP positions were established, together with approximately 100 new positions for specialists.

Fig. 5.3 shows that Norway in 2003 had the best physician coverage among the Nordic countries and the EU. The number of physicians has increased much faster than in the other countries – an increase of around 50%. In 1990, Finland and Norway had the poorest physician coverage in the Nordic countries, a ratio of 390 physicians per capita in Norway, while in 2002 this ratio was 275 physicians per capita (a reduction of 29%). The reason for this is the increase in medical student positions during the 1990s. The number of medical students from abroad increased from 579 in 1994/1995 to 1934 in 2002/2003. Extrapolation in Helsemod has predicted a balance between the supply and demand of physicians to 2010.

Towards the end of the 1990s the supply of physiotherapists increased and it is currently sufficient to meet the demand. The estimates in Helsemod point to an oversupply in physiotherapists approximately in the period between 2005 and 2020.

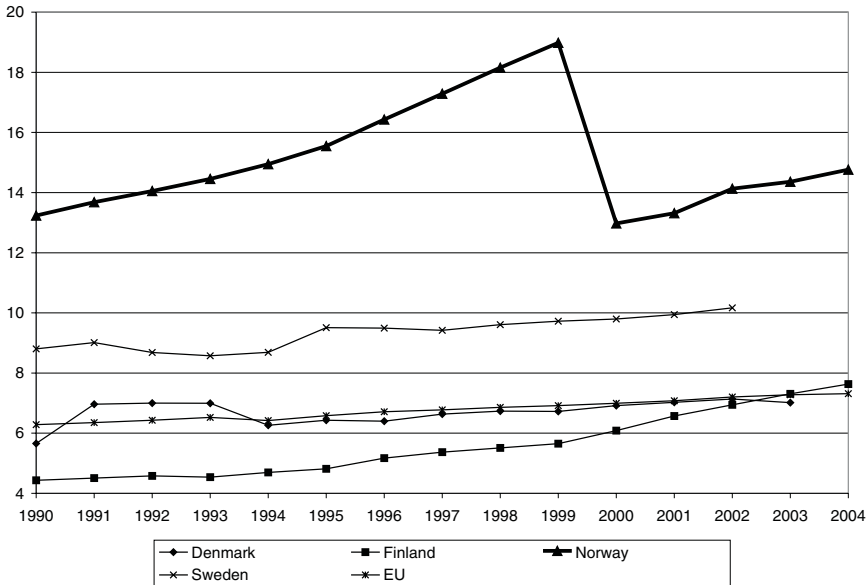
Within the Norwegian health care system, managers are often recruited from the clinical professions. It is common for nurses and, first of all, physicians to occupy management positions in the health service. We are not aware of

Fig. 5.3 Number of physicians in Norway and selected countries per 1000 inhabitants, 1990–2004 or latest available year



Source: European Health for All database, January 2006.

Fig. 5.4 Number of nurses in Norway and selected countries per 1000 population in 1990–2004 or latest available year



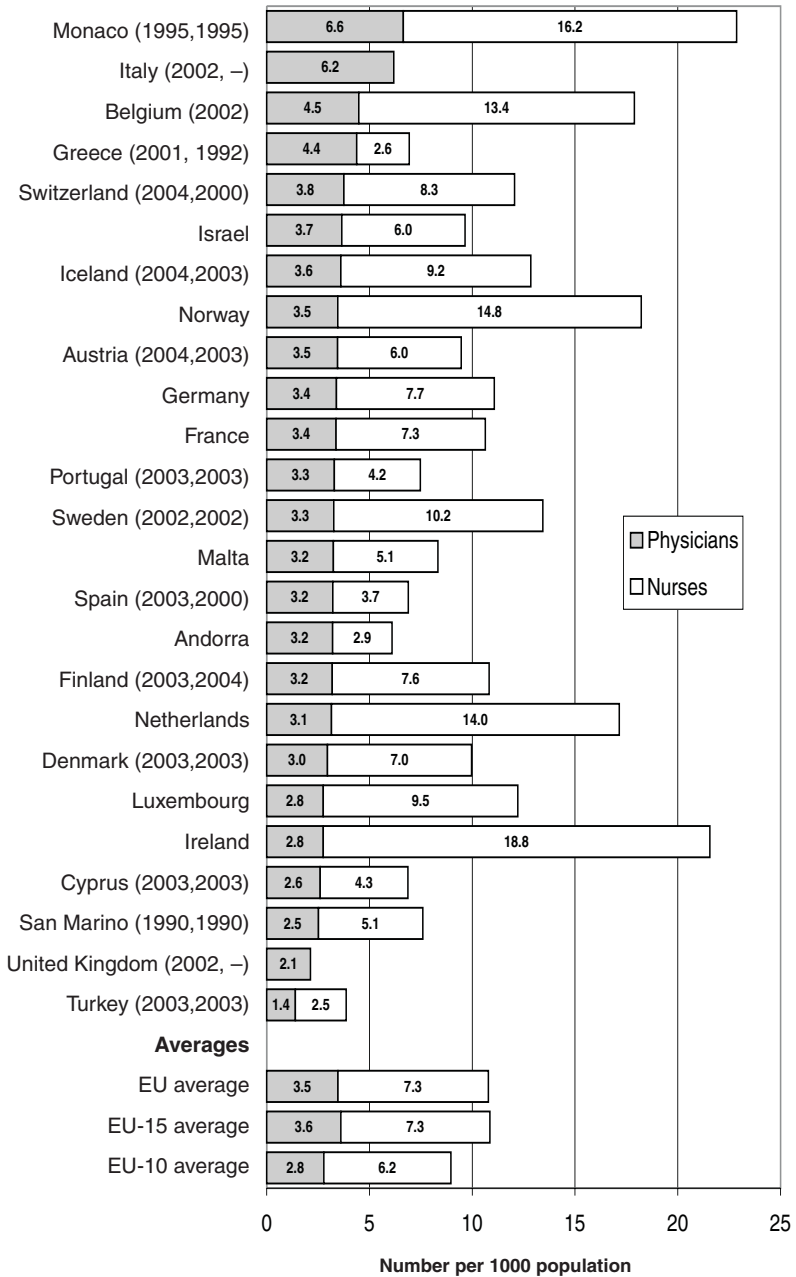
Source: European Health for All database, January 2006.

any published studies describing the educational background of people with management positions in the health care sector, or how this changed following hospital reform. From 2002 to 2005 there were no politicians on the boards in the regional health authorities. The occupational background of regional executive board members in 2003 was: public sector 64% (42% from the health sector and 22% from other parts of the public sector), private sector 24%, 4% retired and 7% unknown. As of 2006, this has changed, and politicians make up the majority of the Board members in the regional health authorities.

The total numbers of physicians and nurses working in somatic and psychiatric hospitals, as well as in primary care, have been increasing since 1990. This has been due in part to a general expansion in higher education in Norway during the 1990s, which in turn resulted in an increase in the number of educated personnel in the health care sector. However, according to Nomesco, statistics on health care personnel in the health services are very incomplete, and it is, therefore, difficult to compare the situation among the Nordic countries.

The number of students willing to become psychologists has increased from 100 in 1990 to 230 in 2003. Without an increase there will be undersupply of psychologists towards 2010. But an increase of the number of physicians

Fig. 5.5 Number of physicians and nurses per 1000 population in western Europe, 2004 or latest available year (in parentheses)



Source: European Health for All database, January 2006.

Note: EU: European Union; EU-15: Member States before 1 May 2004; EU-10: Member States joining the EU 1 May 2004.

in future and an increase in the number of psychiatrists may outweigh the undersupply of psychologists.

The total number of dentists was stable during the 1990s in Norway, but the number working in the public sector has decreased from 1260 man years in 1990 to 891 man years in 2002. Currently, more than 70% of the dentists are private. In 2002, there was a peak of 181 unoccupied public positions for dentists. The number of unfilled positions varies between counties, from 0% to 30%. In the private dental sector it is difficult to find successors in less central areas. In order to increase the number of dentists a new odontology institute was established at the University of Tromsø, but the effect on supply will not be noticeable until 2011. In the meantime, there has been recruitment from other countries. For example, 56 contracts were signed with German dentists in 2003 through Aetat's recruitment programme, and in 2004 this programme was expanded to all EU countries. There are also training programmes for dentists outside the EU area.

Planning of health care personnel

In Norway there is long tradition that the government regulates the physicians' labour market. The purpose of the regulation has been to make it easier to recruit physicians in rural areas and to ensure that there is an adequate number of educational positions within each specialty (Brenne 2003). From 1979 to 1984 and from 1988 to 1989 temporary laws put restrictions on establishing new physician positions in central areas. In the 1980s two treaties were made between the physicians' union, the then Ministry of Social Affairs (Sosialdepartementet), the Norwegian Association for Local and Regional Authorities (KS) and the municipality of Oslo to regulate the specialist structure and the geographic distribution of physicians.

Under the treaties, municipalities and hospitals that wanted to set up a physician position were obliged to apply to a council appointed by the treaty holders in order to obtain a permit. By the middle of the 1990s, when there was a significant shortage of physicians, some institutions, especially hospitals in the larger cities, disregarded the treaties and began to employ physicians without obtaining the necessary permits. The treaty covering the geographical distribution of physicians was evaluated in 1996 and it was concluded that the regulation was not working. According to the evaluation report, an important reason for the failure of the regulation was that the treaty did not involve any sanction mechanism. The government acted and a law was passed in parliament in 1998 that made it a requirement for a permit to be obtained from the Ministry of Health and Care Services before a physician could be employed in

a publicly financed position. The National Council for Physician Distribution and Specialist Structure was set up to advise the Ministry of Health and Care Services. The new regulatory regime came into effect on 1 April 1999.

Since the beginning of the 1990s, Statistics Norway has, in cooperation with different government agencies, developed a model framework called Helsemod to be used in estimating future supply and demand for health personnel. Since the Norwegian Directorate for Health and Social Affairs was established in 2002 (see section 1.2) it has cooperated closely with Statistics Norway on this matter. The estimates based on the modelling done by Statistics Norway are a vital instrument for the government in planning the future supply of health personnel.

Since 1982 the Ministry of Health and Care Services has been responsible for regulating specialist education. The ministry receives advice on these issues from a council with the representatives drawn from, among others, the medical faculties and the Norwegian Medical Association. From 1998 this has been The National Council for Specialist Education of Physicians and Physician Distribution.

It has always been more difficult to recruit physicians to positions in rural areas than in urban areas. There are also differences among the specialties. The rate of unoccupied positions has been especially high for GPs and for positions in less popular specialties such as psychiatry and community medicine (Brenne 2003).

Training of health care personnel

Before looking at the details in this section, it is necessary to outline some general aspects of the Norwegian education system. An important objective of the Norwegian education system is that everyone should enjoy equal educational opportunities regardless of their social background. There are no tuition fees for public education at any level in Norway. Private institutions with tuition fees constitute only a very small part of the education sector, and they mostly offer mercantile-oriented degrees. Higher education students currently receive about NKr 80 000 in scholarships and loans each year. The municipalities are responsible for the 10 years of basic education. The counties are responsible for the tertiary education level; most students at this level are between 16 and 19 years old.

Four public universities in Norway admit students onto medical study programmes (there are no private educational establishments offering this education in Norway). The education capacity of the Norwegian medical

faculties for 2003 was 156 in Oslo, 139 in Bergen, 91 in Trondheim and 79 in Tromsø.

Admittance is based on grades from the tertiary education diploma. Applicants receive credit for courses at university level. The admittance criteria are the same for all four medical faculties. The clinical training takes place at several different hospitals. All four medical faculties have their own curricula, which differ, especially in teaching methods and in how the study progresses. However, there have been no known problems regarding the learning outcomes despite these differences. The curricula at the medical faculties are not subject to detailed regulation or standardization from the government. Coordination and standardization of the medical education in Norway is done through formal and informal cooperation between the medical faculties. It is common for corresponding departments at the different universities to have regular meetings to discuss issues regarding the basic education of physicians (Brenne 2003).

The 6-year basic medical education is followed by an internship period of 18 months. The Norwegian Registration Authority for Health Personnel is responsible for the administration of the intern service. The 18-month internship period consists of six months on a medical ward, six months on a surgical ward and a final six months in general practice. Norwegian and foreign students with the basic medical education from a Norwegian or foreign university and those with a medical licence from a number of countries outside the European Union also need to complete the internship period in Norway in order to receive a Norwegian physician licence.

The internship period for physicians in Norway has traditionally been an important regional policy tool. The intern positions have been concentrated in rural areas.

There are 30 basic specialties (including psychiatrists) and eight medical and five surgical branch specialties. The average minimum time required to obtain a specialty is five years but, in practice, it can take much longer – on average nine years – but there are large variations between the specialties (Brenne 2003). Within the Norwegian Medical Association there is one committee for each basic and branch specialty. These committees make important decisions about specialist education, such as certifying hospital wards for specialist education and approving courses. Formally the committees give advice to the Norwegian Medical Association's National Board, which in turn decides what policy the Norwegian Medical Association members in the National Council for Specialist Education of Physicians and Physician Distribution should promote.

There are 27 educational institutions in Norway offering the basic nursing education; 22 of these are university colleges, and the rest are located at health care institutions. The standard minimum requirement for the nursing education

is to have reached general study competence (which normally means that the student has completed three years of tertiary education). The Competence Reform (see section 3.1) has made it possible for people over 25 without general study competence, but with extended work experience in the health care sector, to be admitted into nursing education. Basic nurse education lasts for three years. Half of this time, 60 weeks, is devoted to practical work, of which between 32 and 42 weeks are spent in health care institutions. The further education programmes leading to specialist nursing degrees normally require some clinical work experience and take from one to two years to complete. It is common for students attending the full-time further education programmes to be paid an allowance by the employer during their studies. In exchange they commit themselves to work for that employer for an agreed number of years after finishing their specialist education. Many of the nursing education institutions have programmes for distance learning. These programmes make it possible for people to acquire nursing education if they cannot easily attend classes, for example because of family commitments. The development of communication technology has made this easier to organize. Those attending these courses often have work experience from the health care sector, and their employers sponsor parts of the courses. Municipalities located away from larger educational centres can provide training programmes in nursing. Nursing science is established as an academic discipline, with masters' degrees and PhDs. The Ministry of Education and Research regulates nursing education according to a framework plan.

The regional health authorities are responsible for providing nursing students, medical school students and some other health profession students (such as bioengineering or radiography) with practice places. The Ministry of Health and Care Services pays the university colleges to compensate for any expenses incurred due to students' practice period.

Auxiliary nurse education in Norway takes place at the tertiary education level, and is organized by the counties. Traditionally, it attracts mostly women over the age of 20. In a reform of the tertiary education system in 1994 (Reform 94), everyone born after 1978 was given a legal right to tertiary education. The Competence Reform gives adults born prior to 1978 the right to tertiary education. It also introduces a system whereby people can be assessed based on their earlier work experience, and based on this 'real competence' they may qualify for authorization directly or they may be required to take some courses. As a part of the health personnel recruitment plan the government intends to target resources to enable existing unqualified personnel to be authorized as auxiliary nurses. The most important impact of the Competence Reform has probably been to strengthen the recruitment into the auxiliary nurse profession.

Three public universities in Norway admit students on to the five-year dental study programmes (there are no private educational establishments offering this education in Norway). The first two years of education are integrated with the medical students' programmes, and after that the candidates follow specialist dental training. The educational capacity for the Norwegian dental faculties in 2003 was 51 in Oslo, 38 in Bergen, and 0 in Tromsø, since the first students started in autumn 2004.

The University of Oslo and the University of Tromsø educate pharmacists on five-year masters' programmes. This usually includes a six-month practice placement in a hospital or at an ordinary chemist's shop during the course of their studies. The educational capacity for 2003 was 55 in Oslo and 24 in Tromsø. The University of Bergen offers a three-year course (bachelor degree) with a capacity of 25 in 2003. Four public universities in Norway admit students to the five-year psychology study programmes. In order to satisfy the entrance requirements, candidates must pass a one-year study course in psychology taught at the universities. The educational capacity for 2003 was around 96 in Oslo, 71 in Bergen, 38 in Trondheim and 21 in Tromsø. University colleges are responsible for educating physiotherapists. Several university colleges have been offering physiotherapists' programmes since 2005. The educational capacity for 2003 was 254. With the introduction of the hospital reform in 2002 there has been an increased focus on leadership training within the public hospital sector. This was mentioned in the letter of instruction to the regional health authorities in 2003.

Since 1973, Norway has had a combined licensing and certification law for psychologists. To be allowed to practise as a psychologist, a person must hold a university degree in professional psychology. The Norwegian psychology degree (Cand. Psych.) is awarded after six years of academic and professional study: this degree can be obtained at the University of Oslo (96 candidates in 2003), the University of Bergen (71 candidates in 2003), the University of Science and Technology in Trondheim (38 candidates in 2003) and the University of Tromsø (21 candidates in 2003). The educational capacity for 2004 was around 230.

Until recently, there has only been one education programme at the public universities offering education in management for the health sector. Since 1986 the Centre for Health Administration, which is connected to the medical faculty at the University of Oslo, has offered a full-time programme targeted at health personnel with work experience. This has now developed into an 18-month Master of Health Administration degree. Around 400 students have graduated so far, most of them physicians. In 2002, the Centre for Health Administration started to admit students onto a new study programme offering bachelor's and master's degrees in health management and health economics. Other university

institutions and private institutions today offer small-scale health management training programmes.

Registration/licensing

The Health Care Personnel Act sets out the regulations with regard to the authorization and licensing of health personnel. The Norwegian Registration Authority for Health Personnel (SAFH) is responsible for granting professional authorization, which an applicant requires in order to practise within the legally regulated health personnel categories. Authorization represents full and permanent approval, while a licence imposes one or more limitations with respect to duration, independent or supervised practice, etc.

Authorization is granted subject to the following conditions: the applicant has passed an exam in the relevant subject at a Norwegian university or college or through occupational training at a secondary level, has completed practical training in accordance with regulations laid down by the ministry, is less than 75 years old, and is not considered to be unsuited for the profession.

Through the European Economic Agreement (EØS) Norway is obligated to use the EU directives relating to mutual recognition of education also in the case of health personnel. According to the Health Personnel Act, an applicant from a country outside the EEA may also be authorized if she or he has passed a foreign examination that is recognized as being equivalent to its Norwegian counterpart, or has otherwise been proven to possess the necessary skills.

The Norwegian Board of Health is the government agency that makes decisions on disciplinary measures in the event of medical malpractice. For instance, if the Norwegian Board of Health finds serious failure and/or indefensible neglect of duty the individual risks withdrawal of his or her licence.

6 Provision of services

6.1 Public health

Municipalities are responsible for health promotion, the prevention of illness and injuries, and, in relation to that, the organization and management of school health services, health centres and child health care. The central government has five central public health institutions, which are professional and administrative bodies under the authority of the Ministry of Health and Care Services: Norwegian Directorate for Health and Social Affairs, Board of Health, National Institute for Public Health, Norwegian Medicines Agency and Norwegian Radiation Protection Authority. The main objective for the Norwegian Directorate for Health and Social Affairs is to ensure that social and health issues exert a strong influence on the general public choice of lifestyle and behaviour, and that importance is given to health care and social issues in connection with political decisions in all sectors of society. The main objective of the National Institute of Public Health is to monitor the development of the nation's state of health, and implement new public health knowledge in programmes that favour positive determinants on health. The Board of Health is the state inspectorate for health services.

The White Paper Report no. 16 (2002–2003) *Prescriptions for a Healthier Norway*: a broad policy for public health, outlines the national public health strategies for the next 10 years. Its objective is a healthier Norway through a policy that contributes to more years of healthy life for the population as a whole and a reduction in health inequalities between social classes, ethnic groups and genders. This White Paper advocates a broad public health policy. It is concerned with many factors which cause health problems and which help to protect us from disease. It draws attention to the connections between the individual's and the community's responsibility for health and aims to define responsibilities in

a number of sectors and policy areas. The White Paper focuses especially on physical activity, nutrition, tobacco, alcohol and drugs and mental health. One of the targets outlined in this White Paper is to reduce smoking among young people by 50% over a five-year period. The Norwegian Parliament passed a bill to ban smoking in restaurants, cafés and bars, which came into effect on 1 July 2004. Other initiatives include school-based programs and campaigns against smoking in the mass media. The government introduced an action plan on alcohol and drug-related problems in 2002, to cover the period up to 2005. Norway's strategy on alcohol and drugs abuse is based on prevention, treatment, rehabilitation and harm reduction actions. Reducing inequalities in health is a priority. The White Paper notes that previous public health policy did not focus on diversity in the health of the population. The White Paper recognizes that great potential for improvement lies in addressing the health of disadvantaged segments of the population.

Mental health is becoming an increasingly important area in the Norwegian health system. The Escalation Plan for Mental Health (1999–2008) was adopted in 1999 and is the overall strategy for mental health. In this document special emphasis is given to children's mental health. The Strategy for Children's and Young People's Mental Health was published in 2003. In addition a National Plan for Self-Help was launched in 2004, which aims to promote self-help as a tool in the prevention of mental problems.

In 1991 Norway laid down regulations in relation to Systematic Health, Environmental and Safety Activities in Enterprises (Internal Control Regulations) as a common legal instrument and a tool for the five different public authorities at central level. The purpose of the regulation is the promotion of continuous improvement in enterprises in the following areas: working environment and safety, protection of the environment from pollution, prevention of health damage or environmental disturbances from products or consumer services, and improved treatment of waste.

Norway has a national screening programme. One example is the public screening programme for breast cancer (mammography), a service that is available for all women aged 50–69 years old. The programme started in 1995 and covered up to 80% of women during the first four years; it included all women in 2003. The aim is to reduce the incidence of breast cancer among women, but there has been a debate over the effects of this programme. The National Board for Priorities in the Health Care System in 2002 recommended that the programme might play a less important role in the national health service, and that there should be an increase in the participants' fee payments. There is also a nationwide screening programme for cervical cancer, started in 1995, which aims to reduce the incidence and mortality of cervical cancer, and at the same time contribute to a more efficient use of the number of cytological

smears taken every year. Women aged 25–69 are recommended to take a smear test every third year.

6.2 Patient pathways

Normally the patients' first contact is with the regular general practitioner. There are also emergency ward scheme (LV centres or on-call physicians) in all municipalities (see section 6.5). Referral to the specialist health care service is conducted by the physician based on medical reasons. The physicians at the municipalities level (the patient's regular GP and the emergency wards GP) have a gatekeeping role for the specialist health care. However, in the case of critical incidents (e.g. traffic accidents), the patient may be sent directly to the hospital emergency department at the nearest hospital. Regarding elective care, the regular GP either makes an appointment for the patient with an appropriate caregiver (i.e. with a private specialist with agreement, a radiology centre or a hospital) or provides a referral so that the patient can arrange his or her own appointment. This system is uniform throughout the country; neither the municipalities nor the regional health authorities have the right to change it: for instance, they cannot levy extra out-of-pocket payments or challenge the gate keeping role of the physicians.

A 60-year-old woman with a light limp and pain in the hip might typically have the following experiences in the Norwegian health care system:

- She visits her regular GP with whom she is registered, the GP examines her, makes the tentative diagnosis of arthritis, and refers her for a radiology examination. Co-payments are involved for most outpatient consultations.
- The GP refers her to a hospital orthopaedic department, normally a public hospital in the region, for examination and, subsequently, an operation. She will have to wait several months for elective surgery.
- She has free access to any public hospital in Norway, and her GP might advise her to seek treatment in a hospital with short waiting lists.
- She can choose to go to a private hospital (although the number of private beds in Norway is very limited), but she must pay for treatment in a private hospital directly. Currently only a few patients would choose this option.
- Her GP prescribes any necessary medication before, but not during, hospitalization.
- Following surgery and primary rehabilitation at the hospital the patient goes home, where she might need home care (home nursing and/or home

assistance). If this is prescribed by the hospital or her GP, it will be provided by the municipality free of charge.

- The GP is responsible for any further follow-up such as referral to a physiotherapist (to whom the patient will have to pay a small co-payment).
- A follow-up hospital visit is likely to take place to check the treatment's outcome.
- The National Health Insurance covers part of the costs at the GP's surgery, travel, part of the cost of the examinations, all inpatient and rehabilitation costs at the hospital, and part of the cost of physiotherapy.

6.3 Primary/ambulatory care

The state has employed medical officers since the early 1600s. Over time, a core of District Medical Officers developed, and private practitioners settled in the cities. From 1860 to 1984, there were municipal boards of public health, chaired by the state-employed district medical officer, with the rest of their members locally elected. The medical officer was allowed to see patients privately, as far as his public duties would allow. With general health insurance, private practice grew dramatically during the 1960s, often at the cost of public health duties.

The health boards were dismantled in 1984 and the municipal councils were made responsible for financing and providing primary health care with financial support from the state. The councils were free to decide whether to hire GPs as public employees or to contract them as private physicians.

A variety of different acts describe the municipalities' responsibility. According to the Municipalities Health Services Act (1982), the Act on the Protection of Children (1992) and the Act on Social Services (1991), the municipalities are responsible for preventive efforts and for providing and financing most primary health care and social services. The rights in these laws also apply to people with mental problems. The laws establish a broad mandate for local politicians to shape local structures. In 1987, the Municipalities Health Services Act was extended to include environmentally oriented health activities. In 1988, the task of managing nursing homes was shifted from the counties to the municipalities, and the responsibility of local health care authorities was further increased in 1991, to include the care of the mentally disabled.

Municipalities are, therefore, responsible for the following tasks: prevention, diagnosis and treatment of illness, injuries and physical defects and provision of nursing care and care outside health care institutions. The municipalities

provide the following statutory services: general medical practice, which involves a duty roster, physiotherapy, nursing, including health visits and home nursing services, midwifery services, nursing homes or care homes with-24 hour nursing care, and medical emergency call services.

The local authorities promote health and the well-being of the population as well as ensuring good social and environmental conditions. They seek to prevent and give treatment in the case of illness, injury or infirmity. Furthermore, they provide information on health and encourage activities in the community to promote public health and individual health and well-being. The decision about the amount of local funds that should be spent on the health sector is left to the discretion of local politicians. However, the Municipalities Health Services Act defines a number of obligatory services.

One of these services concerns public health and preventive measures within the paediatric area. Preventive maternity care and childcare are usually provided at local health centres and municipality schools. All children and young people under the age of 18 receive regular dental care with emphasis on preventive care. The dental health of this age group has improved significantly since the 1970s.

Primary health care, and general practice, or family medicine, is well established in Norway. In 1997, each municipality was given the responsibility to provide a named physician for every citizen according to a patients' list system. The municipalities meet this obligation through contracts with GPs, which calls for every GP to give priority to the patients on his or her list. Patients who do not participate in the regular GP scheme have to pay higher user fees when consulting a GP. There were approximately 20 000 persons (0.5% of total population) who were not registered with the GP scheme in 2004. However, the municipalities are obliged to offer persons outside the regular GP scheme essential medical aid. This applies also to tourists and commuters.

The new system, which was implemented nationwide in June 2001, is based on:

- a registration system whereby citizens sign on to the list of the GP of their choice;
- the basic principle that everyone can choose whether they want to participate in the system or not;
- an individual's right to choose another physician as their GP (no more than twice a year) and the right to a second opinion by another GP.

GPs are central to the primary care system, and the most common practice structures comprise teams of two to six physicians. They also have auxiliary personnel. Most GPs specialize in general/family medicine. On 30 September

2003 there were 3711 GPs in the system, of which 2931 (78%) participated in a local emergency ward. The responsibilities of general practitioners include making a diagnosis at an early stage of disease, treating simple everyday problems and referring patients to specialists when necessary. Physiotherapists or chiropractors can treat the patient directly, although these providers only receive reimbursement when they receive a referral. In order for specialists to be reimbursed for a consultation from the NIS, the patient needs a referral from a GP.

The implementation of the regular GP scheme represented a major change in the primary health care system. This reform has been evaluated from the start by several research projects commissioned by the Ministry of Health and Care Services. Hopefully, the reform will guarantee every citizen a steady relationship with a GP. This is especially important for people with chronic diseases, disabled people, substance abusers etc.

According to the Ministry of Health and Care Services, the GP scheme is functioning well, with 98% of the population having a regular GP. The share of “very satisfied” patients has risen from 32% in 2000 to 44% in 2004. Two-thirds of the GPs are satisfied with the scheme, and 35% are more satisfied with their working conditions now than before the introduction of the scheme. As mentioned previously, 99.5% of the population participates in the regular GP scheme, while 21 000 persons (0.5%) have chosen to remain outside.

6.4 Specialized ambulatory care/inpatient care

The recent transfer of responsibility for all Norwegian hospitals to the central government represents a radical break with a tradition going back more than 30 years, where hospitals were owned and managed by the 19 county councils.

The previous system of hospital administration contained elements both of a decentralized and a centralized system. It allowed local politicians to be involved in the hospital management structures, something for which they had neither training nor experience. Moreover, they failed to take appropriate strategic decisions on the local hospital system, or introduce a rational division of labour among component units. Often such necessary changes were not compatible with local political interests. Furthermore, ownership of 80 hospitals serving a population of 4 500 000 people across 19 counties presented an excessively top-heavy administrative structure.

In January 2002, the Norwegian Hospital Reform was implemented and the responsibility was transferred from the counties to the five regional health authorities. The reform divided the country into five health regions (Fig. 6.1).

Each region is now responsible for its own regional health enterprise, which in turn owns the hospitals in that region. Every regional health enterprise has a statutory duty to provide equal access to hospital services for those who live in its catchment area. Subsequently a new Health Enterprise Act has now placed the sole responsibility for the delivery of holistic and specialized health care on the government, and in order to achieve this objective, the state has taken over the ownership of hospitals.

Each hospital is now a discrete legal entity, with a board of management responsible for all activities. Thus, while hospitals may be state owned, they actually remain decentralized and self-governing. Each regional enterprise is set up with an executive board appointed by the Ministry of Health and Care Services and managed by a chief executive officer. The same model also applies to individual health enterprises. Another important feature of these reforms has been to transfer to health enterprises full responsibility for the use of capital as well as other inputs.

The function of the health enterprises is to deliver specialized health care services of high quality equally to anyone in need, irrespective of age, gender, location, economy, or ethnic background, as well as facilitating research and innovation. The reform gives the enterprises a higher degree of freedom than the hospitals previously had, with regard to investments, flexible planning and health services production, organization and use of resources across their organizations and accounting.

Owing to restructuring in 2003, the number of health enterprises (e.g. local hospital trusts) was reduced from 43 at the end of 2002 to 31 at the end of 2003. Consequently, there are fewer and larger health enterprises. The restructuring has been particularly extensive in eastern Norway (Helse Øst RHF), where they were reduced from 15 in 2002 to 7 in 2003, and in southern Norway (Helse Sør RHF), where the reduction was from 13 to 10. The Regional Health Authority Centre Norway (Helse Midt-Norge RHF) included five health enterprises at the end of 2003.

Specialist health care includes both somatic and psychiatric institutions, as well as other specialized medical services, such as laboratory, radiology and ambulatory care, and special care for alcoholics and drug addicts. Tertiary care is also part of the regional health authorities' responsibility.

The regional health authorities may contract out some services to private hospitals or agencies. Following the hospital reform, the degree of private contracting has increased.

The regional health authorities are financed via global budgets, activity-based funding and patients' out-of-pocket payments. Somatic health care services are financed via the DRG system or from fee-for-service tariffs. The regional

health authorities are free to allocate this income, but in practice the state's reimbursements are sent directly to the local health enterprise.

In the United Nations 2004 report (cited in St.prp nr 1, 2004–2005) Norway is ranked number one with regard to resource use, accessibility and level of health care services. Availability and accessibility of services is fair and good, the challenges faced by the health care system and specialist health care are determined by the demographic structure of the country. For instance, Helse-Nord has a scattered population and receives more money from the global budget per capita.

Both discharges from inpatient care and ambulatory care consultations have increased the last 10 years, by more than 25% from 1992 to 2003. There has also been a shift from inpatient treatments to ambulatory care treatments. The increased activity is reflected in a growth in the positions for physicians and nurses. In the HiT 2000 report waiting lists were an issue: “the most urgent problem facing the health care system in the past decade has been the insufficient ability of both somatic and psychiatry hospitals to absorb patient inflows”. Today it would seem that this issue is less important, and that the government actually wants to moderate the activity level in somatic care. For instance, the activity level in 2003 exceeded the target set by St prp nr 1 (2003–2004) by about 5%.

In Norway ambulatory care is mainly conducted by the health enterprises where physicians provide inpatient and ambulatory health care services in the same hospital building. Today all hospitals offer ambulatory care services. In 2003, approximately 3.3 million ambulatory care consultations were conducted, among which 3.2 million were conducted in public hospitals or by specialists with regional health authorities' agreement. Private physicians without the agreement with regional health authorities carried out approximately 3% of all consultations.

With regard to ambulatory care, there are also self-employed specialists who work in their own practices. These specialists have an agreement with the regional health authorities and receive a subsidy from them (normally a yearly lump sum, from around NKr 500 000 to 1 million) and reimbursement from the NIS based on fee-for-service. In 2003, 1083 operating agreements and 722 man years were contracted between the health enterprises and different medical specialists, which included specialists in the field of obstetrics and gynaecology, ear nose and throat diseases, and internal medicine, with ophthalmology being among the most common.

The regional health authorities are obliged to supply all inhabitants with the necessary specialist health care, but some tertiary-level services are situated in only one region. Each region has at least one university hospital. As of 2003,

there were 32 tertiary-level services (landsfunksjoner) at Norwegian hospitals. The same year there were 41 national, highly specialized competence centres. The competence centres mainly conduct activities related to professional development, competence evaluation and counselling, but sometimes also manage the process of patient treatment.

The Ministry of Health and Care Services can instruct hospitals to provide tertiary-level care services, and has the right to close them down. Norway is the only Nordic country where the central government is directly involved in the decision process of supplying tertiary level health care services. Sweden, Denmark and Finland have delegated this to their municipalities/regional authorities. Before 2003, tertiary services were financed by earmarked means from the state, but today this is part of the regional health authorities' global budgeting, except for funding to the competence centres which still is financed by earmarked means. Most of the tertiary-level services are conducted at health enterprises situated in the major cities, often in coordination with the universities.

Surveys (NOU 2003:1) have shown that the patients' access to tertiary-level services is unequal. Patients who live close to a tertiary-level hospital (situated in one place) tends to be overrepresented (see St.meld. nr 5, 2003–2004).¹¹ For example, patients from the Oslo area tend to be overrepresented at tertiary-level services at Rikshospitalet, which is situated in Oslo. In order to solve this problem the state has phased out the fixed patient prices and allowed the regions themselves to set the patient prices for tertiary-level care. The Ministry of Health and Care Services can intervene if the five regions cannot reach an agreement about prices among themselves. Furthermore, a development project has been set up to develop DRGs for tertiary-level treatments, in order to ensure a more accurate reimbursement of tertiary-level services.

The regional health authorities have two distinct roles that appear to conflict, according to the Ministry of Health and Care Services: as authorities, to ensure that all tasks defined by the health legislation actually are met, and in leading and managing local trusts in the region.

The regional health authorities, as provider, to meet the patients' rights (legal demands) and ensure that every citizen gets access to specialized health care services, if needed. In terms of strategic planning, regional health authorities assess the actual needs as well as future needs. The regional health authorities have to use their own enterprises as well as the private sector. The regions are

¹¹ This trend is also relevant for mental health; figures from Sirius show that the number of hospitalizations and consultations was 20% higher in those municipalities where the mental health institution was located than in others (NOU 2005: 18).

responsible for the management of hospitals and for financial issues. Cost control and quality improvement are important objectives. Implementation of these objectives along with restructuring of services has caused some local protests.

There has been a substitution policy that aimed to replace relatively expensive inpatient care with less-costly outpatient and domiciliary care. This is reflected in fewer hospital days per patient and more outpatient treatments. The average hospital stay has been reduced from 7.5 days per stay in 1989 to 5.2 days per stay in 2004. Since 1990, the number of hospital beds has decreased by around 2000, from 16 000 in 1990 to 14 000 in 2003. As a result, an increasing number of patients receive treatment in their own homes, the goal being to offer the patient the best possible care at the lowest possible cost. For instance, dialysis treatment is defined as a specialist health care service. However, during the last few years it has become possible for decentralized dialysis to take place in nursing homes and this has become the municipalities' responsibility, reimbursed with activity-based funding.

The specialist health services have a duty to guide the municipal health services. This involves giving advice about the population's health conditions that are required so that the municipal health services always act in accordance with the law and maintain sound professional standards. For example, after a paediatrician has made a diagnosis and instituted treatment for, say, a child suffering from epilepsy, he or she must give appropriate advice to the patient's GP regarding the follow-up. The advice is free of charge for the municipal health services and the GPs.

The specialist health services have established mobile teams (ambulante team), often with different health care professionals, that work outside the hospital and guide and help patients at home or in institutions. These teams are common in the case of geriatric and cancer treatments.

NOU 2005:3 discusses the appropriate balance between primary health care and specialist health care. According to NOU 2005:3 the perception of health care specialists about the readiness of patient to be discharged may conflict with the municipalities' readiness to receive and follow up the patient at, for instance, a nursing home or with the provision of home based services. One of the suggestions in NOU 2005:3 is to direct the municipalities and the health enterprises to create a cooperation agreement in order to achieve a more seamless delivery of patient treatments.

Day care¹²

The last two decades has seen a trend for shorter hospital stays and expanded day care in the area of specialist health care. Statistics Norway showed that for somatic specialist health care, there were around 2.5 million cases of ambulatory care and around 0.6 million inpatient discharges (ratio of 4:1) in 1990. In 2004 these figures were approximately 3.4 million cases of ambulatory care (poliklinikkonsultasjoner) and 0.5 million day surgery cases (dagkirurgi). In sum there are around 4 millions ambulatory care cases and 0.8 million discharges each year (ratio of 5:1). The financing of all day-care treatments was based on fee-for-service until 1999 when the activity-based funding system (Innsatsstyrt finansiering, ISF) based on DRG included day care defined as day surgery (dagkirurgi). The statistics from Samdata 2004, based on DRG points for day surgery, show a growth of 50% from 1999 to 2004, while as of today, 2006, around 50% of all medical surgery is conducted as day surgery.

6.5 Emergency care

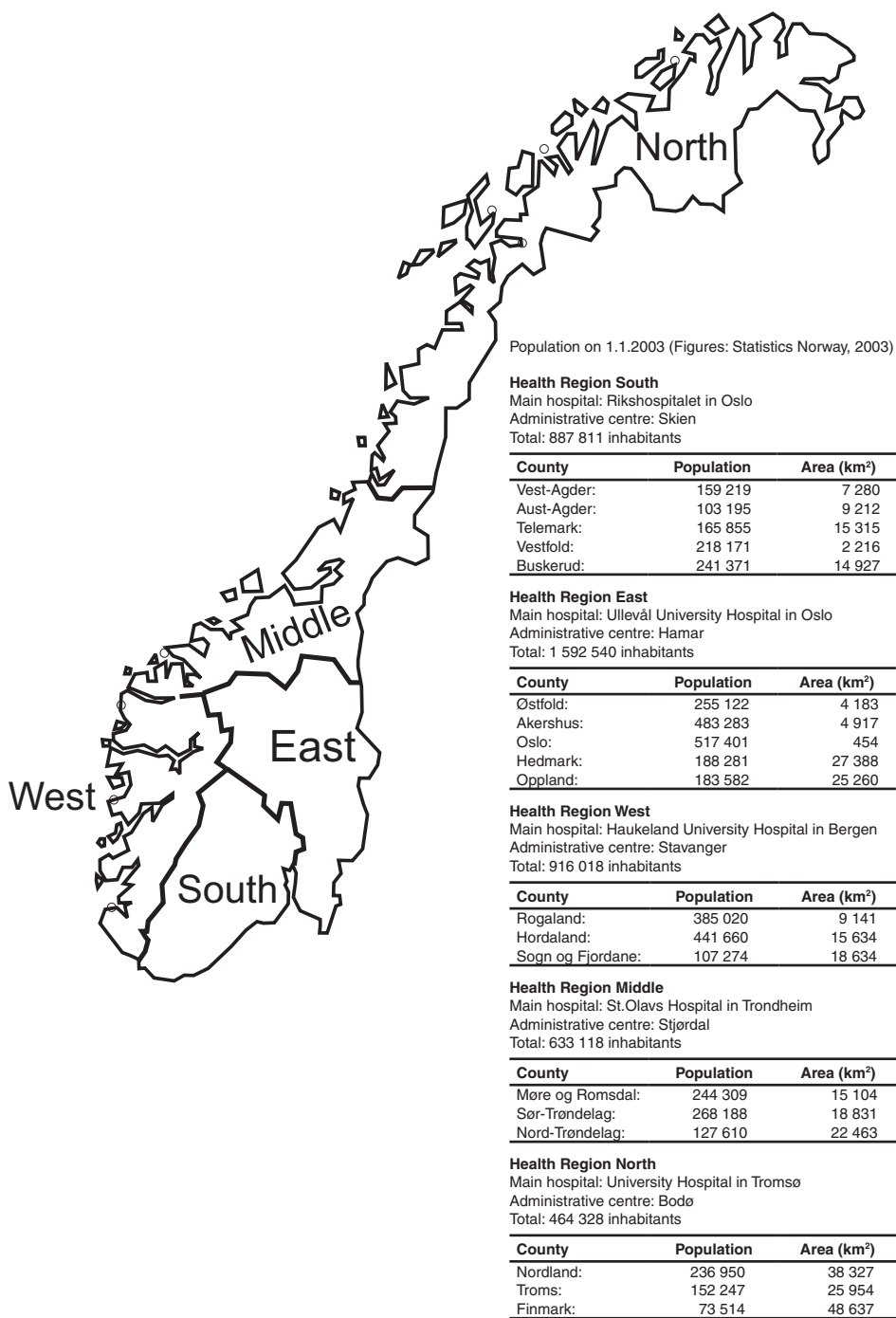
The pre-hospital emergency health care includes the ambulance services, emergency medical communication centres, centres for municipal GPs and physicians on call. The provision of pre-hospital emergency care in Norway is shared between the primary and specialist health care services, that is, the municipalities and the regional health authorities.

GPs are responsible for providing acute primary care during surgery hours. Responsibility for providing acute primary care outside these hours lies with the municipalities and is organized through the GP-on-call system. Contact between the public and the GP on call takes place via the GP on-call centres. These GPs are required, by regulations, to be available on “the national health radio network”. In some, typically small and remote, municipalities, the home nursing services more or less formally constitute part of the municipal pre-hospital emergency care. If this is formalized, the nurses will also have to be available on the network. In general, however, home nursing services are, at present, not considered users of the radio system.

The ambulance services constitute the main part of the pre-hospital emergency care provided by the health regions. The services are either provided by the regions themselves, or by contractors. In both cases the health regions are responsible for the services.

¹² In Norwegian health statistics there are three levels: inpatient with DRG reimbursement, day surgery cases with DRG-reimbursements, and ambulatory care cases with fee-for-service reimbursements.

Fig. 6.1 Regional health authorities



Ambulances are based either at hospital or in the community. Depending on the size of the population they are staffed either with hospital personnel, or are on call from home. In recent years there has been a substantial development in the ambulance services, with advanced treatment now being provided by ambulance staff. This places greater demands than before on the communication systems, with data transmission gradually becoming ever more important. Ambulance services in Norway are provided by cars, boats and helicopters. Advanced ambulances, including air ambulance, are staffed with physicians in addition to other health care staff.

As well as the ambulance services, the hospitals provide emergency medical teams. These typically consist of physicians and nurses. The emergency medical teams are not part of the day-to-day operation of pre-hospital care, but are mobilized for larger cases.

Three different kinds of communication centres/control rooms are included in the running of the emergency health care services of Norway:

1. Emergency Medical Communication Centres (AMKs) (Akuttmedisinsk kommunikasjonsentral). These combine the functions of Public Safety Answering Points for the medical emergency number (113), and Emergency Control Centres for health. The number of AMKs has been reduced in recent years, the present number being 21 nationally. Each AMK covers one or more hospitals with emergency medical activities. The tasks performed are:

- call-taking on emergency number 113;
- assessment of the case;
- advice on emergency medical procedures to inhabitants;
- dispatch of relevant resources (ambulances, physicians and other health care resources);
- mobilization of, and communication with, relevant hospital resources;
- administrative and professional communication with relevant resources throughout the handling of the case.

The AMKs are staffed with health personnel, including registered nurses and ambulance coordinators. The number of personnel varies depending of the size of the population of each centre, but there is a tendency towards reducing the number of centres, and creating fewer and larger centres.

2. Accident and Emergency Departments (AEDs) (Akuttmottak). These are typically where the hospital primarily receives incoming emergency cases. The AED needs to be able to communicate with ambulance services and other health resources involved in pre-hospital emergency care. The purpose is to provide advice, and ensure that necessary preparations are made to receive

the patients. An AED is typically manned by registered nurses. These exist in all hospitals providing emergency hospital care.

3. Municipal GP on-call centres (LV centres) (Legevaktssentral). The municipalities in Norway run the primary health care emergency services, which are performed by contracted GPs. These services include a LV centre, which receives calls from the public on locally dedicated telephone lines (normal 8-digit telephone numbers). The centres need to be connected to the digital radio system for contact with GPs and ambulances. LV centres are usually staffed with registered nurses who provide advice, assess the situation and provide contact with GPs on call and other relevant resources. Whereas larger LV centres have permanently employed nurses and are open throughout the day and night, others function only between set times (e.g. from 4 p.m. until 8 a.m.). Two or more municipalities may collaborate to run joint centres, either day and night, or part time. The staff at smaller centres may perform other duties as well as answering telephone calls and communicating with health resources. The trend in recent years has been to increase collaboration between municipalities, and hence the need is now for fewer and larger LV centres. In some cases the function of the LV centre is performed by an AMK on contract with municipalities. LV centres collaborate with the AMK in the handling of acute emergencies which require the involvement of specialist health services.

It is expected that a new joint digital radio communication system called “Nødnett” will be in use countrywide by 2009, and will be used by the Norwegian public safety authorities, including services of police, fire brigades and the health care sector.

6.6 Pharmaceutical care

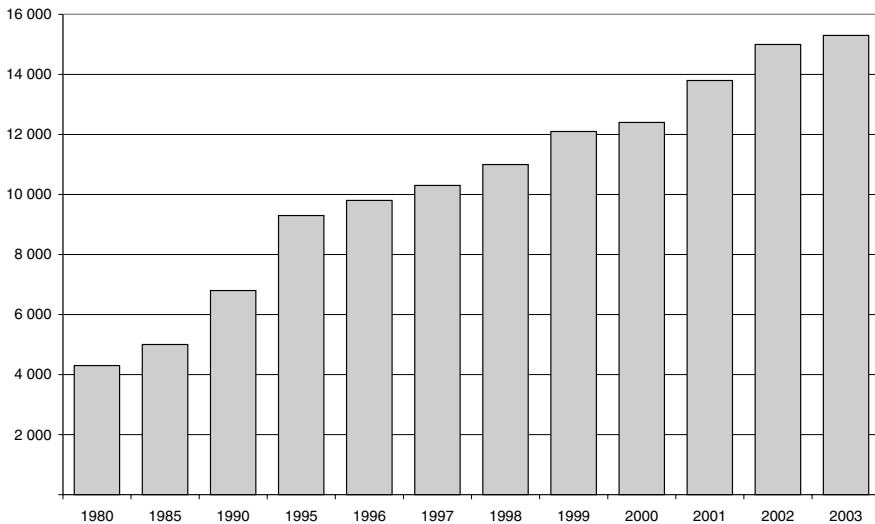
Expenditure on pharmaceuticals as a proportion of the total expenditure has increased several times during the last two decades in Norway (see Fig. 6.2). In 2003, total sales on pharmaceuticals were approximately NKr 14.7 billion (measured in retail pharmacy prices). In total, the government financed around two-thirds of pharmaceutical consumption in 2003. The remainder was made up of patient fees, non-prescription medicines and non-reimbursed medicines. Pharmaceutical expenditure was around 0.7% of GDP or 8.4% of public financing on health expenditure in 2003. Sales of medicines per capita in Norway in 2003 amounted to approximately NKr 3220.

Until 1992, Norway allowed patents for the process of making pharmaceuticals, but not for the end product itself. The purpose of the ban was

to protect the domestic industry, which relied significantly on manufacturing patented foreign drugs (NOU 1997:6). Norway signed the TRIPS agreement in 1994, which regulates pharmaceutical patents between countries.

The pharmaceutical sector is one of the most regulated sectors in Norway. The Norwegian Ministry of Health and Care Services has overall supervisory responsibility for pharmaceuticals and sets the retail margins. The Norwegian Medicines Agency, which is a subordinate agency of the Norwegian Ministry of Health and Care Services, registers and allows new types of drugs onto the drug market in Norway. In 2004, the number of market authorizations was 6046.

Fig. 6.2 Medicine sales, pharmacy retail price (PRP) (in Nkr millions nominal currency)



Source: LMI/Farmastat and Statistics Norway, 2004.

The Norwegian Medicines Agency was created in 2001, replacing the former Medicines Control Authority. The department for pharmacies and drugs at the National Board of Health and part of the National Insurance Administration today form the Norwegian Medicines Agency.

The Norwegian Medicines Agency has the following responsibilities:

- to set the prices that the pharmacies pay to the distributors (Apotekenes innkjøpspris, AIP) and that patients pay for the drugs in the pharmacies (Apotekenes utsalgpris, AUP);

- to supervise drugs from the manufacturers to the end users of the pharmaceuticals;
- to distribute the licences for production and trade with drugs/ pharmaceuticals;
- to evaluate applications for reimbursement of a new drug and make decisions.

The National Insurance Administration (Trygdeetaten) administers the NIS. An important element of the NIS is the blue prescription rule (blåreseptordningen). Based on this rule, the NIS reimburses the patients for the majority of their expenditures on important drugs. The flow of pharmaceuticals from manufacturers to the end users is illustrated in Fig. 6.3. Total public reimbursement of drugs has increased substantially each year, from NKr 5085 million in 1996 to NKr 8336 million in 2003, owing to the introduction of new and more expensive drugs, among other market factors. The reference price system was introduced in 1993 in order to reduce costs and dictated that the price of the cheapest brand available on the market within each group of identical drugs should be the basis for reimbursement.

In 2000, the reference price system was abandoned owing to poor results, after a research conducted by ECON (Econ report 44/2000) showed that the state saved less than expected, and the patients had to bear a large share of the government's savings. Administration costs for physicians and pharmacies were also high. Today the main rule applied when pricing a prescription drug in Norway is that the price is set at the average of the three lowest market prices for that product in selected countries. If none is available in three or more of the countries that are included in the price comparison, the price will usually be set at the mean price in the countries where such a market exists. Countries that are normally included in the price comparison group are: Sweden, Finland, Denmark, Germany, Great Britain, the Netherlands, Austria, Belgium and Ireland. The price set by the Norwegian Medicines Agency specifies the maximum market price to the pharmacist. The product can be freely sold, however, at a lower price than the maximum price.

In 2001 a new law was passed allowing greater freedom in the establishment of pharmacies. Previously, the Norwegian Board of Health was responsible for locating pharmacies so as to adequately cover the whole population, with the result that Norway had the lowest availability of pharmacies in Europe. A permit is now required from the Norwegian Medicines Agency and so far every application has been accepted. As a result of the law, the market is dominated by three chains, which also control the retailers, with a total market share of around 90%. The number of pharmacies has grown from 355 in 1995 to 519 in 2003 or 46% (in 2005 the figures reached 558). In addition, there are

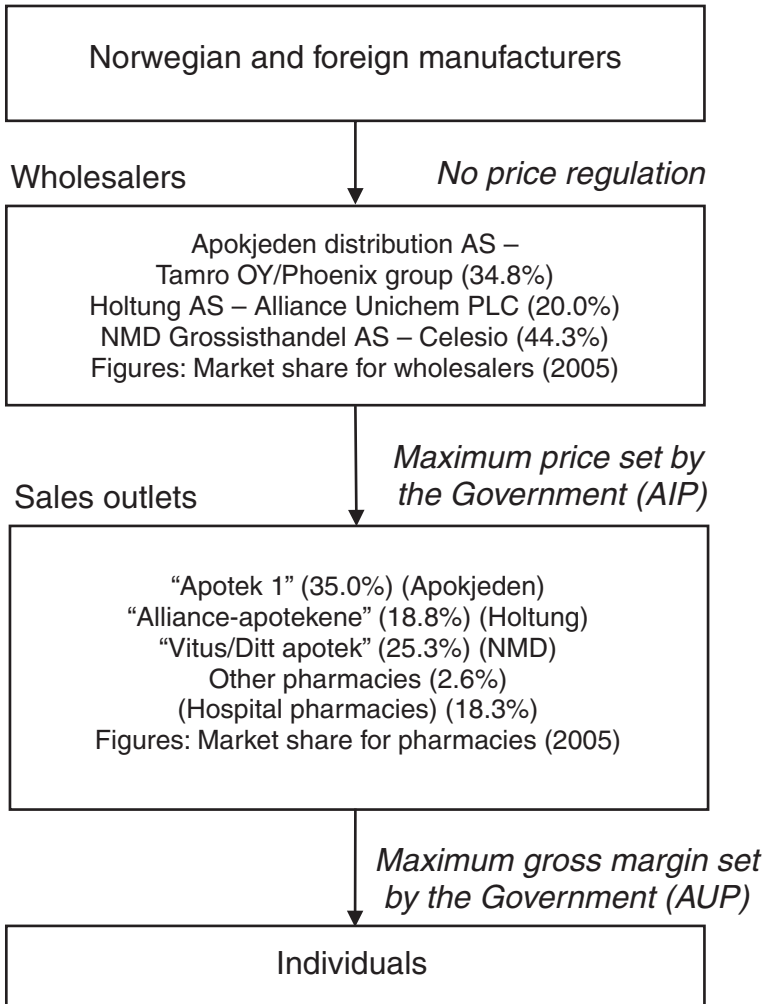
approximately 1150 drug stores, without a pharmacist working there. Following hospital reform, most of the hospital pharmacies are today organized as health enterprises, forming a total of five pharmacy health enterprises, in each of the five health regions.

The law has not only changed the structure of ownership, but it also allowed pharmacies to change the physicians' prescriptions to another brand (e.g. generic or a parallel-imported drug) according to the Medicines Agency substitution list. The patient and/or the physician can resist the change. It should be noted that neither the patient nor the physician has any economic incentives to make the change; and no additional costs will be incurred in choosing an expensive drug rather than a cheap generic drug. It is the pharmacist who has the economic incentive. Generic substitution is driven by the price set by producers, as this price is not regulated by the state. But the overall results have seen a growing number of generic firms in Norway and an increasing market share for generics.

In 2003 a new index price system was implemented, allowing the retailer to gain extra margins for choosing a cheaper drug instead of a more expensive one. The system was abandoned in 2005 and replaced by the step-price system (trinnprissystemet) that in practice cuts the generic drug price after a specific period of time. Since 1995, there has been no price regulation of non-prescription drugs. Most of the hospitals buy their drugs either through a body called LIS that negotiates directly with the manufactures or through wholesalers. The deals have a value of about NKr 830 million (or 85% of the hospital market), with an average discount of about 31%, measured according to the pharmacies' retail prices. In addition to supplying drugs to the public, the pharmacies are responsible for providing information about drugs to public and to physicians. On 1 November 2003, the pharmacists' monopoly situation changed and from then on they were allowed to sell some non-prescription drugs in other retailers such as petrol stations and grocery stores.

There is strong pressure from the pharmaceutical industry to have new products registered and covered by the NIS under the Blue prescription scheme. Increasing pressure from patients and their families can also be expected in the future. This is the case in most countries as patients' expectations and knowledge increase. It should be noted that the devolution of pharmaceutical budgets to GPs, which are covered by the NIS, is not a practice in Norway and this has not been an issue of discussion.

Fig. 6.3 Flow of pharmaceuticals from manufactures to end users and price regulation model



6.7 Rehabilitation¹³/intermediate care

During the last few years the perspective of rehabilitation in Norway has been widened, so that it focuses not only on improving functions, but takes also a more holistic approach. The goal of the Norwegian Government is to promote independence and participation on the part of individual users, and to facilitate

¹³ For Norwegian readers: the term “rehabilitation” in this section includes “habilitering”.

a life of dignity and equal opportunities for persons with functional problems and chronic diseases. To reach such goals requires comprehensive cooperation between several sectors and areas.

There are several institutions offering rehabilitation services, such as: children's hospitals treating pulmonary conditions, asthma and allergy, competence centres on rare diagnoses, training and information centres for users with rare diagnoses and their families, special pedagogic competence centres, health sports centres and special training centres for adults, and specialist institutions for lung diseases.

The municipalities have major responsibilities in ensuring that the coordination of the rehabilitation services is functioning according to the needs of the service users, which requires close cooperation with the health enterprises, the regular GPs, the child health and maternity services, nurses etc. The municipalities cooperate with the National Insurance Administration and their local offices, including assertive technology service delivery centres, and the Labour Market Administration. Cooperation with user organizations and their peering services is also important. Rehabilitation normally takes place in the patients' homes or in nursing homes, while for long-term institutionalized rehabilitation, the municipalities often purchase beds in private institutions.

The regional health authorities are obliged to coordinate the rehabilitation work. Rehabilitation services are conducted at the specialist health care level in special rehabilitation hospitals, in ordinary hospitals and in other institutions. Most hospitals have organized rehabilitation as part of their medical departments and in special departments, and are financed partly by activity-based funding. Rehabilitation is also conducted in private institutions, especially post-operative rehabilitation, and following GP referral. These private institutions used to be financed by the NIS, but are at present funded by the regional health authorities, who are, as a result, given better incentives to see the rehabilitation field as a holistic and integrated process.

There are challenges in developing rehabilitation programmes in local communities, such as providing equitable services to all groups across municipalities and health regions, ensuring cross-sector cooperation and cooperation across different levels and organizations, ensuring real and active user participation, improving professional competence and facilitating common fundamental approaches across professions. In particular, the coordination responsibility includes functions such as registration of rehabilitation needs, ensuring and following up holistic individual rehabilitation plans, and ensuring interdisciplinary approaches, and initiating, administrating and following up the interdisciplinary groups, constituting a core in the cooperation with regional health institutions.

In 2001, in order to develop a more inclusive workplace, the government introduced a four-year tripartite agreement scheme (Inkluderende arbeidsliv) between the employer, employees and the NIS. Enterprises that sign this agreement are giving special and exclusive rights, such as the right to take sick leave without prior consent from the NIS, and a regular contact person at the NIS to help employers follow up employees who are on sick leave. Occupational health services in the enterprises are given a special refund rate under the NIS to help to bring employees on prolonged sick leave back to work and get them off disability benefits. The employee's right to take sick leave without a physician's certificate is extended to eight calendar days per absence with a total upper limit of 24 days per year. The objectives for the inclusive workplace agreement are to reduce absenteeism through sickness, to provide employment for a far greater number of employees whose functional capacity is impaired (employees with occupational disabilities or on rehabilitation schemes, or reactivated employees on disability benefits), to increase the real retirement age. In 2005, this agreement was extended for a further four years with more emphasis on preventive work and inclusion of disabled people.

6.8 Long-term care

The organization of long-term care in Norway is the responsibility of the municipalities, and all municipalities run one or more long-term nursing homes. There are three types of long-term care services, i.e. nursing homes (sykehjem), sheltered houses (lifetime homes, pleie- og omsorgsboliger), and home-based services (hjemmebaserte tjenester). None of these services is earmarked for the elderly. Since the mid-1990s there has been a clear rise in the number of users of nursing and care services provided by local government primarily as a result of the growing need for home care. More people receive nursing care at home (approximately 162 000 in 2002, compared to 142 000 in 1992); at the same time, the number of residents in sheltered homes has grown (30 260 in 1994 and 46 414 in 2002).

Recently the number of places in nursing homes has decreased somewhat, partly as a result of renovations aimed at providing more single bedrooms, which now stand at 88%. In 1992 there were 45 571 residents in nursing homes, compared to 41 635 in 2002. Nursing homes are regulated by the Municipalities Health Services Act, which regulates services conducted in the nursing homes, as opposed to the care given in homes and sheltered houses, which are regulated by the Social Services Act.

The basic principle behind care of the elderly and of disabled people is that services and individualized support should be arranged in ways that enable people to be cared for in their own homes. The elderly and those with disabilities should have the opportunity to live in their own home for as long as possible. Nurses and home care personnel make home visits and provide necessary services, including personal care. Home care (community-based) services include cleaning, shopping, cooking and washing for those who cannot cope on their own. Care services also include respite care, physiotherapist services, activities-for-daily-living training and personal assistance. Increasingly, information technology is used to enhance the safety and independence of the users, such as telecom safety devices, etc. Around 41 500 of the 162 000 people receiving home care were under 67 years in 2002.

The number of sheltered houses has been increasing in the last 10 years and there has been some earmarked funding from the state in order to encourage further building. These sheltered houses offer residents all the same services as home care and are often connected to the municipalities' long-term nursing homes. Approximately 14 500 (30%) of the people living in homes for the aged and disabled in 2002 were under 67 years old.

Nursing homes are designed for residents who require a high degree of care. The most important health reasons for caring are: dementia illnesses and heart- and lung-related illnesses. An average patient will require five different drugs, has mobility problems, needs personal care, help with eating, and may be incontinent (Romøren 2003). Around 18% of the beds attached to special care units are for persons with dementia. There are also rehabilitation departments in the nursing homes, where a patient can stay for short periods, for instance, after a hospital stay. The average patient is around 85 years old: only around 1700 persons (4%) living in shelter houses were below the age of 67 in 2002. In all five regional health authorities there are organized long-term nursing homes attached to academic teaching institutes.

Since the 1980s, the municipalities have had a high degree of freedom in deciding how services should be organized, so long as they comply with national health standards (for instance there are some municipalities who own and run nursing homes in Spain for Norwegian patients). As a result, some municipalities have developed traditional nursing homes, whereas others have established sheltered houses. This was the intention in the four-year action plan for the elderly in 1997, where the municipalities received a high degree of freedom to shape the services based on local evaluations and needs. The action plan for elderly care adopted by the parliament was followed by a grant of NKr 30 billion.

The division between nursing homes and lifetime houses is not clear cut. Some homes are organized with services that resemble nursing homes, others are more like private homes; and there are also elderly day-care centres. On average, the user of a sheltered house may have fewer caring needs than the user of a nursing home. There has been an increase in the number of man-years in long-term care. In 2002, nurses carried out approximately 94 000 man-years in the municipalities, physicians and physiotherapists excluded, an increase of 40% from 1992 (when the number of man-years carried out was 66 500). In general, the municipalities directly employ the personnel working in the sector. Some nursing homes belong to and are managed by voluntary organizations. However, they are staffed by professionals and are funded by the municipalities. Until now, very few enterprises involved commercial entrepreneurs.

The local authorities are empowered to provide, revise, or cease the health and social services available to individuals as set out in the Municipalities Health Care Act and the Social Services Act. The local government is free to establish the procedures of eligibility. A patient's eligibility for home care is decided either by one or more persons working for the provider of the service, or by an independent unit within the local government's health care system. When it comes to care provided in nursing homes, there is a team responsible for this task, consisting of persons working for the providing units as well as other parts of the local government's health care system. A request for health care or social services may be made by the person requiring help, by his or her relatives, or by any other person. The application is subjected to a thorough assessment of the applicant's actual needs, irrespective of any potential help that may be forthcoming from relatives, during which the applicant is given every possible opportunity to present his or her case. The patient's GP will also make recommendations on behalf of the patient with regard to the level of care.

IPLOS – National statistics linked to individual needs for care

Even though central government is not directly involved in the provision of nursing care, it has established an obligatory information system called IPLOS (Individbasert pleie- og omsorgsstatistikk) for use by the municipalities and central government. IPLOS provides a standardized set of information about any seeker or recipient of health or social help (nursing and care sector) from local authorities. IPLOS is expected to be in general use by 2006, and must be seen in together with other information system –KOSTRA (an abbreviation for “Local authorities state reporting”). The aim is that information provided should be relevant and a necessary requirement in processing and responding to service requests, as well as in decision-making and planning by local authorities and the government.

6.9 Services for informal carers

In a historical perspective, the work previously undertaken by informal carers have gradually become the responsibility of the government. Among other things, the development of health and social services in Norway is for the most part synonymous with the history of voluntary work. The voluntary organizations have different systems of values, organizational forms and working areas, and represent a broad and diverse scale of activities. Municipalities have a legal obligation to support people with particular comprehensive caring tasks. These arrangements are a kind of support to informal carers. However, the government wants to make an evaluation of the different arrangements and see them in association with the aims of the welfare policy.

Nongovernmental organizations (NGOs) have two important roles in public health work. Their first role is to initiate and facilitate actions to promote healthy living and quality of life. Other organizations, such as consumers' organizations, those dealing with the areas of culture, recreation and lifestyle, and the broad public health organizations are important partners in public health work. Their second role is to contribute actively to policy-making on behalf of their members. NGOs are valuable partners for local and regional authorities in the public health chain.

Since the late 1980s, the Norwegian Government has paid more attention to voluntary organizations. A Royal Commission report was published in 1988 (see NOU 1988:17). This was the first general presentation of the "third sector" in Norway, and the report gave a broad picture of the national voluntary organizations in the sector. In the late 1990s several White Papers on voluntary organizations and their relationship with the authorities were presented. The intention was to look at the economic frameworks of the voluntary organizations and describe their role in society. Voluntary organizations play a major role in creating services in the health and social sectors. Different organizations for patients and disabled people play an important role in questions connected to people's situations, for example, diabetes, Alzheimer's disease, heart diseases, Parkinson's disease.

6.10 Palliative care

Palliative departments are established at nine hospitals, whose departmental capacity varies between two and 12 beds. The first, and largest, was established in 1994 at the university hospital in Trondheim. At the same time two traditional

hospices were established in Bergen and Oslo. Some 13 more hospitals are planning to establish palliative teams and departments. A total of 35 nursing homes throughout the country have palliative units, these units vary with regard to size and volume; from palliative beds in close cooperation with specialist hospitals to earmark-funded palliative beds in small municipalities. This means that the provision of medical services will vary, and that the degree of treatment will be reflected in the medical and nursing professional competences at the local/unit level.

There are five centres of palliative expertise (one in each health region) and representatives from these centres together with the Norwegian Association for Palliative Medicine in 2004 set up national guidelines for the organization of palliative care. The Norwegian Medical Association launched national guidelines on pain relief in 2004.

Today there are 12 palliative care support teams established in the country. These are hospital-based teams which work under the direction of hospital departments and primary health care. Usually these teams are equipped with, at least, a physician and a nurse with special training in palliative care, and are often supplemented by, for example, priests, psychologists, physiotherapists and social workers. The main tasks of these teams are to advise the hospital on specific patients' situations and to contribute to internal training and competence build-up at the hospital and the hospital's surroundings.

Palliative care is approved as a professional field (a special area organized under the Norwegian Medical Association), but the profession is not a medical specialty in itself (neither is it considered as such in other Nordic countries). The palliative teams consist of physicians from different specialties with special interests in the field. In order to elevate the skills for physicians working in palliative care, the Nordic Specialist Course in Palliative Medicine has been established in Norway; the course syllabus covers the theoretical topics from countries where palliative care is a specialty.

Three Royal Commissions (NOU 1984:30, NOU 1997:20 and NOU 1999:2) provide the legal background with regard to the organization of palliative care. The commissions' main recommendations refer to the strengthening of home care and locating nursing homes in suitable locations. To this end every municipality should have at least one physician and nurse with special competence in palliative care and assist other health care personnel with advice and guidance. It should have its own inpatient units, ambulatory and ambulance palliative care teams at larger regional hospitals, regional palliative care competence centres and sections on palliative care at university hospitals in each region. In recent years these recommendations have been implemented

with the establishment of palliative care teams and units and supported by earmarked means from the state budget.

Palliative nursing care is not a nursing specialty in Norway. Since most of the patients at palliative units are cancer patients and it will, therefore, be nurses with cancer specialization who will most likely work with the palliative care teams. This specialist education is common in all health regions. There are also interdisciplinary post-experience courses on palliative care, which are aimed at nurses, social workers, physiotherapists and others. All the palliative units, teams or arrangements are interdisciplinary, which means that the patients have access to physiotherapists, clergymen and social workers in addition to nurses and physicians. The Royal Commissions mentioned above stressed the importance of interdisciplinary work for this patient group in ordinary hospital beds. Also, there are established hospice units at hospitals (mostly in urban areas) for inpatients. These are run as specialist palliative care units for inpatients and ambulatory care.

All palliative units offer in some form a bereavement support service for families. Many hospitals have established specialist provision for individuals with a high degree of palliative care needs to access secondary-care facilities. There are, for instance, arrangements with nurses who act as a link between the hospital and the patients' home (thereby bypassing the GP/gatekeeper).

Palliative care services rely to a small degree on volunteers, but many of the palliative units, like day care, ambulatory care, hospital or nursing home beds, and home-care nursing have a staff of volunteers. The volunteers attend a training course and are frequently followed up by professional health care personnel. Volunteers are an important additional resource in palliative care. Both patients and relatives should be involved in the preparation of the individual treatment plan. However, it is not easy to achieve this in practice.

The focus on palliative care has increased during the last ten years for all patient groups that are reflected in many of the projects in hospitals, nursing homes, and in general teaching. There have been a number of research publications on pain and pain management, and on the effect of palliative treatments, including patients' and relatives' satisfaction.

6.11 Mental health care¹⁴

Until relatively recently, Norway, like other western countries, had traditional psychiatric institutions and mental hospitals that were responsible for treating patients with mental disorders. However, during the 1990s, mental health became a priority on Norway's political agenda. Since the mid-1990s, the government has formulated important mental health policies regarding the organization and content of mental health services and care, and the underlying principles which permeate the whole system.

A White Paper (St.meld. nr 25, 1996–1997) was issued in 1997. This government report analysed the current situation regarding mental health services in the population and pointed out a host of flaws in the existing service system on all levels:

- inadequate preventive measures
- lack of/inadequate services at the municipal level
- poor access to specialized health services
- hospital admissions and inpatient stays often short term despite patients' needs for longer inpatient stays
- hospital discharges not sufficiently planned
- poor follow-up systems and routines after discharge.

In addition, it was noticed that patients were not receiving the help and services they needed. Health professionals and staff did not feel they were doing a good enough job, and the authorities were unable to supply the public with adequate and well-functioning services (St meld nr 25, 1996–1997).

The government report gave rise to a national mental health programme/reform (St prp nr 63, 1997–1998) adopted by the Norwegian Parliament in 1998. The programme was extended to apply to the period 1999–2008 and represents a number of strategies and measures targeting national, regional and local levels in the entire country. The overall goal is to create adequate, coherent and well-functioning services at all levels for people suffering from mental illness.

This national mental health programme requires considerable financial resources and support from the government. Essential features in the programme include:

- a phasing-out period for traditional psychiatric services and mental institutions (de-institutionalization);

¹⁴ The contribution of John William Glad to this section is gratefully acknowledged.

- a reorganization of mental health services (a decentralized model where the main component is the community mental health centre (CMHC) (Distriktpsikiatriske sentre, DPS));
- building up and strengthening municipal and local community services to people suffering from mental disorders;
- participation of service users' organizations and other mental health advocacy groups on all levels of government work regarding mental health issues;
- special focus on children and adolescents with mental problems and disorders;
- information strategies and educational campaigns targeting children and adolescents, service users and providers, workplaces and various occupational settings, in addition to information strategies targeting the general public;
- education and research in the field of mental health;
- training and recruitment of qualified professionals and staff working with people suffering from ill mental health.

Making sure services are delivered in a way that is user-focused and user-friendly is one of the key components of the mental health policy. The mental health programme aims at improving availability, accessibility, quality and organization of mental health services and treatment at all levels. Furthermore, it is specifically a challenge to develop a smoother collaboration and cooperation between primary health and social services (municipal level) and specialized health services.

The municipalities play an essential role in the provision and coordination of services to people suffering from mental illness. Thus, on the municipal level, the national mental health programme specifically focuses on:

- satisfactory housing and accommodation with adequate assistance if necessary;
- promotion of participation in labour market/occupational activities for people with mental illness;
- activities targeting the need for social contact, feeling of connectedness and integration;
- adequate and well-functioning health and social services along with preventive measures.

Furthermore, special attention is given to children and adolescents at the municipal level. Services to this group are directed towards those who have already developed problems/disorders or who are in the "danger zone". Teachers and public health nurses ("helsesøstre") are important co-players in this area.

The GP plays a major role in municipal health issues. The regular GP scheme was a reform that was implemented in Norway in June 2001. The objectives of this reform are:

- to give the citizens improved access to GP services;
- continuity in physician–patient relationships;
- an increased rational utilization of the country’s total medical resources by improving collaboration between the primary and specialist health services.

The GP is responsible for following up patients on his or her list, thereby maintaining a degree of continuity in the physician–patient relationship. This is particularly important for patients suffering from mental illness. More specifically, the GP is responsible for planning and coordinating preventive work, examination and evaluation, and finally, treatment. The GP provides an important link between primary health care and the specialized health services, and is, in many ways, a gatekeeper. The GP’s knowledge and understanding of a patient makes it easier to decide when it is time to refer the patient to the specialized health services.

In summary, the efforts on mental health in the municipality are quite broad, targeting schools and educational systems, public health nurses, areas concerned with housing and accommodation, the workplace and labour market, social services and primary health physicians.

The specialized mental health service consists of three main categories:

- mental hospitals with specialized functions;
- CMHC;
- private practising psychiatrists and psychologists who receive financial support from the government, thus keeping out-of-pocket payments at an acceptable level for the patients/service-users.

From an organizational, and also ideological, point of view, the cornerstone of the national mental health programme is the CMHC, a model that evolved in many western countries during the late 1980s and 1990s. The main objective for the CMHC is to collaborate with the hospitals on the one hand, and with the primary health care and municipal services on the other, thus creating a coherent and well-functioning line of services for the service user.

The CMHC concept is still being developed. However, most agree that the CMHC should in the long term develop optimal functions adapted to local conditions. Thus, it is to be expected that CMHCs will differ somewhat from each other, according to local and geographical characteristics. It is here important to bear in mind that Norway is one of the most sparsely inhabited

countries in Europe, and has a low population density compared to many other countries.

An appropriate population coverage for a CMHC has been estimated to be somewhere between approximately 30 000 and 60 000, according to government health authorities. However, figures from SINTEF points out that currently most CMHCs have a population coverage closer to 60 000 (upper limit). This may indicate that many CMHCs will already need to expand, to recruit qualified mental health professionals and staff, to create a rich and creative professional and academic environment.

The report points out that by mid-2003 86% of the country was covered by a CMHC. Twelve CMHC areas are still under development, but it is expected that by the end of 2006, the entire country will be sufficiently covered by the CMHC services. The current estimate of the total number of CMHCs in Norway by the end of 2006 is 83. The CMHC consists of a number of units that provide a variety of services:

- Outpatient clinic and services: The outpatient clinic is viewed as the most essential part of the CMHC. The outpatient clinic ordinarily has the most qualified mental health professionals (such as psychiatrists and psychologists with supervisory functions), and subsequently carries out most of the clinical evaluations and examinations. It is usually the outpatient clinic that provides consultation, supervision and professional support to the GPs, municipal services and agencies.
- Day treatment clinic (daytime training/daytime care): This part of the CMHC offers more extensive activities for patients than the outpatient clinic, often consisting of social events and excursions for the service user/patient.
- Crisis resolution and home treatment teams (assertive outreach): these teams visit patients outside the clinic location, often in the patient's home environment in order to make assessments regarding the level of care required. Some teams may be "acute teams" seeking out patients who are developing psychosis, others may be targeted towards certain groups, such as patients in the category labelled "double diagnosis" (patients suffering from combined mental health illness and drug abuse).
- Inpatient units/services: the CMHC has an inpatient unit for patients in need of primarily short-term treatment. Some CMHCs also have some beds reserved for patients needing long-term treatment.

In 1999, four new Acts on health services and care were passed by the Norwegian Parliament. These Acts were viewed as a "health Act package", and consist of the Specialized Health Services Act, the Mental Health Care Act, the Health Care Personnel Act and the Patients' Rights Act. These laws were implemented in 2001.

The Mental Health Act stipulates that psychiatric treatment and services are, from an organizational and administrative point of view, part of the specialized health services. However, certain aspects of mental health services (for instance coercive/mandatory treatment) are regulated by the Mental Health Act. The main objective of this act is to ensure that mental health care, both voluntary and coercive, is carried through in a proper fashion and in accordance with existing rules and regulations that relate to civil rights. This law emphasizes the principle of human rights in connection with patients undergoing treatment, and underlines the importance of promoting voluntary treatment, rather than coercion, wherever possible, thereby emphasizing the importance of the patient's autonomy and right to choose for him/herself.

The system for mandatory/coercive treatment in psychiatry in Scandinavian countries differs from that in many other countries in Europe and the United States. The decision regarding mandatory treatment is made by specialist physicians/psychiatrists or psychologists, but on the basis of a formal request (signature) from a public official (a representative from the police force, social services, the municipal public health officer/physician, etc.), or a family member (father, mother, siblings, children). But, ultimately, it is the physician's, psychiatrist's or the psychologist's decision. The patient must be examined by two independent physicians before the decision is made. Moreover, a patient's compulsory admittance to a hospital is controlled and evaluated by a commission led by a judge. This commission conducts an inquiry regarding the patient's admission process. Overall, the patient has the right to bring his or her case to a regular court. Thus, legal protection of a patient subjected to coercion is a central theme in the Mental Health Care Act.

Statistics reveal that a rather large proportion of admissions to mental health institutions in Norway are coercive. User organizations and advocacy groups have had this issue on their agenda during the past decade. The Directorate for Health and Social Affairs is currently engaged in developing an action plan where the main goal is reduction in, and quality assurance of, coercive treatment in mental health services in Norway.

As we have seen, the National Mental Health Programme in Norway is both extensive and comprehensive, targeting many different aspects and levels in society, rather than just traditional health services. One of the main objectives of the reform is to achieve a collaborative and coherent line of services for users. However, complaints from user/patient organizations and official reports point repeatedly to the fact that different services and entities, both on the same or at different levels, do not sufficiently collaborate and work together, thereby providing the patient with fragmented and incoherent services.

The Norwegian National Board of Health conducted a survey/evaluation of specialized mental health services to adults in 2003 (Board of Health 2004). The report stated among other things that about half of the mental hospitals in the report did not collaborate with the CMHCs, and patients were discharged without adequate follow-up services. Many of the patients had not received their “individual plan”, indicating that there were no formal systems regarding collaboration between the specialized health services and the municipal services.

Across the whole health service system, especially with regard to mental disorders, it is important not just to acknowledge the need for coherence and collaboration among different services and levels of service, but also to implement cooperation and collaboration systems between the different service levels and entities. This is the most important current challenge in the ongoing mental health reform that demands full attention during the next few years.

6.12 Dental health care

Dental health care is the area in Norway where the private element is largest. Around three-quarters of all dentists work in the private sector, while a quarter work in the public sector. There is no regulation of dental fees in the private sector. Therefore, the Norwegian dental health system is following Robinson’s (2002) statement that in many countries, dental services are seen as marginal to the public health system and, for this reason, cost sharing usually constitutes a larger proportion of dental costs than costs of other areas.

According to the Dental Health Care Act, there are five priority groups. These are children and young people aged 0–18 (Group A), mentally handicapped adults (Group B), elderly people and people with a long-standing illness who are either living in an institution or receiving home nursing care (Group C), and young people aged 19–20 (Group D). In addition, the county authorities can decide to give priority to other groups (Group E). The county authorities can also provide dental services for adults who pay for their treatment, if the needs of people in the priority groups have been met. In 2003 there were approximately 1.4 million people under public supervision with regard to dental care, of whom around 1 million were under the age of 18 (Statistics Norway 2004).

Adults over the age of 20 normally pay for their own dental treatment in the private market. The NIS can reimburse certain types of dental treatment, such as maxillo-facial surgery, orthodontic treatment, treatment of the soft tissues in the mouth and jaws, and treatment of periodontitis. Emergency call

dentist services are the responsibility of the counties in cooperation with the municipalities. Usually these services are provided in cooperation with public-employed dentists and private dentists.

Dental health services and dental health personnel are regulated by the same legislation as other health services. A specific national document on the provision of dental health services proclaims: “Teeth for life – health promotion and preventive work”. This booklet is an instruction manual for dental health workers, to be used in health promotion and preventive work. Further, there are national guidelines for dental personnel on the use of filling materials. The Royal Commission (2005: 11) sets out suggestions to strengthen the public dental health care with a budget of around NKr 500 million.

6.13 Complementary and alternative medicine

Complementary and alternative medicine (CAM) is in Norwegian legislation not referred to as “medicine”, but as “alternative treatment”. Practitioners are called correspondingly, and without explicit reference to the concept, “complementary practitioners”. CAM customers are seen essentially as consumers, rather than as patients entitled to patients’ rights. Patients’ rights only apply for established health services as defined in the law, which means that they apply in practice when health personnel are engaged in CAM treatment within, as well as outside, the public health services.

In 2004, a voluntary registration scheme was established for alternative practitioners. Such a scheme confers the status of a professional association that can draw up certain criteria for membership, for those who wish to be registered. If the association fulfils these conditions, its members may, subject to further criteria, be registered in the scheme. In consequence, when drawing up the conditions, the ministry has made a point of: ensuring that patient safety is not compromised, strengthening patients’ right to information, ensuring the integrity of practitioners who must practise in compliance with ethical guidelines and making sure that a complaints procedure for patients is introduced.

The ministry has also implemented non-legal measures. A national information centre on alternative treatment is now being set up, and will be launched in 2006. The purpose of this centre is to provide patients, their family and health personnel with unbiased information on alternative treatment to help them in making informed choices about treatment. To improve information and cooperation a contact forum for professional associations of alternative therapists, user organizations and public authorities has been established. Furthermore, surveys of educational programmes in the field of acupuncture,

homeopathy, naprapathy, osteopathy and manual therapy have been conducted, with a view to authorizing naprapathy, osteopathy and manual therapy as approved treatment. The Consumer Ombudsman and the Norwegian Medicine Agency formally supervise the marketing of alternative medicine products (and also other pharmaceutical products).

Normally alternative treatment is subject to full out-of-pocket expenses for the patient, but it is worth mentioning that in 2001 acupuncture and homeopathic services were exempted from the new VAT on services, and some other therapies (osteopathy, naprapathy, zone therapy/reflexology, nutritional therapy/herbal medicine, aromatherapy, classical massage, kinesiology) have now also been exempted. All CAM treatment is exempt from VAT if it is provided by authorized health personnel.

There are few restrictions in the practice of alternative treatment given in the new Act on Alternative Treatment of Disease, Illness, adopted in 2003. Apart from the following restrictions, anyone may treat people. A practitioner must not describe himself (or herself) as, or claim to be, authorized to give help in or describe himself as a specialist in any type of disease, including calling himself, or passing himself off as, for instance, a physician or dentist. A practitioner must not perform medical interventions or treatment which may cause serious health risks to patients (this means that medical procedures which demand special qualifications are reserved for health personnel (groups as defined in the Health Care Personnel Act). Advertising must be limited to name, address, office hours and general information about the type of therapy and its purpose (no claims to effect are allowed). A practitioner must not treat infectious and communicable diseases which are subject to particular public assistance, or sexually transmitted diseases. Those other than health personnel can treat or alleviate symptoms and strengthen the immune system of patients with various serious diseases, but it is forbidden for them to treat the disease.

In 1998 a Royal Commission (NOU 1998:21) targeted the use of alternative treatment in Norway. The use of such treatments in the country seems to be growing. The “green wave”, growing globalization and travel, increased accessibility, changes in belief systems, self-awareness and responsibility for one’s own health, specialization and increased technology in medical care, have all been suggested as reasons for the increased use of alternative treatments.

Government-funded research was first initiated in 1993, and funding has been granted to several alternative treatment projects. In the autumn of 2000 a National Research Centre for Complementary and Alternative Medicine (NAFKAM) was established at the University of Tromsø. The research and development activity at the centre is now being stepped up, with a particular emphasis on traditional Chinese medicine.

6.14 Health care for specific populations

All population groups in Norway are treated in the mainstream health care system.

7 Principal health care reforms

Ideas that central state governmental steering should be reformed influenced both right- and left-wing politicians in Norway in the 1970s and 1980s. That led to both the Labour Party (Arbeiderpartiet) and the Conservative Party (Høyre) setting up almost identical modernization programmes in 1986 (Schiøtz 2003). The goals were better public services and better use of the state's resources. It was felt that this should be achieved by more professional steering and leadership, based on goals and results rather than on input factors, and increased autonomy of public operations, the larger authority of the labour force and wage policies. In addition, the current rigid personnel policy and a centrally-steered negotiation economy were no longer compatible with an effective central bureaucracy and a public sector. The political consensus with regard to modernization of the country (mainly due to the Labour Party's political shift) led to frequent reforms in the public sector, including the health care sector from the 1980s to the present. This happened in spite of the fact that this was a period of minority governments – left, central and right wing.

Norway has been seen as reluctant reformer (Olsen 1996). Until 1992 major public domains like the railways, telecommunications, the power supply, postal services, forestry, grain sales and public broadcasting were organized as central agencies or government administrative enterprises. But since the mid-1990s greater autonomy has become a major characteristic of the Norwegian style of new public management. The Norwegian reform process consists of a combination of internal delegation of authority to agencies – with emphasis on a performance-assessment regime – and external structural devolution through the establishment of state-owned companies (SOCs) (Christensen and Læg Reid 2001a, 2001b, 2002). As a result of the public reforms, more autonomous and controlling agencies have been established, e.g. the National the Board of Health.

Health care reform focused on diverse issues over the last several decades. During the 1970s the focus was on equality and increasing access to health care services; during the 1980s health reforms aimed at achieving cost containment and decentralizing health care services; during the 1990s the focus was on efficiency and leadership. Since the beginning of the millennium the emphasis has been given to structural changes in the delivery and organization of the health care.

The reforms and changes in the primary and specialist health care sectors have followed different paths (see Table 7.1). At the local level, the municipalities' responsibility and tasks have increased, following the downsizing of institutions in specialist health care in the 1980s and at the beginning of the 1990s. The responsibility for secondary health care services was shifted from the counties to the state, and a new and unique organizational model was set up. At central government level, significant reorganization took place, especially during the 1980s, when the structure of the Directorate for Health was changed and at the beginning of the 1990s, when the National Board of Health was established. In addition, a new structure at the central level was put in place at the beginning of the millennium.

7.1 Analysis of recent reforms

Municipalities health care reform (1984)

The picture of Norwegian primary health care in the 1970s revealed a piecemeal organization, uneven financing, poor coordination, unclear responsibilities and, in the most important sectors, understaffing. As a result of the Municipalities' Health Care Act (1982), responsibility for the primary health care in Norway was transferred to the municipalities in 1984.

The government wanted with this act to coordinate the health and social services at the local level, strengthen these services in relation to institutional care, improve resource utilization, strengthen preventive care, and lay the foundation for better allocation of health care personnel. What attracted most public attention was the financial rearrangements introduced in the act, and the difficult negotiations with the member organizations. For instance, as a result of the reform, the patients pay the same whether they see salaried health personnel or contracted private practitioners.

The Act provided the municipalities with a tool to operate comprehensive health services in a coordinated way, taking local problems and preferences

Table 7.1 Major health care reforms and policy measures, 1984–2004

Year	Reform	Purpose
1984	Municipalities health care reform	Better local coordination of primary health care and social services
1992	HVPU	Downsize institutions for people with developmental disabilities
1997	Activity based financing	Give economic incentives to increase the patient flow
1998	Action plan for elderly	Strengthen the housing and services to elderly locally
1999	Escalation plan for mental health	Strengthen and transform of mental health services both locally and regionally
2001	New health legislations	Strengthen patients' rights
2001	The medical overseas project	Decrease hospitals waiting times by sending patients abroad
2001	The Regular General Practitioners' scheme	Improve the quality of the local medical service and the patient to doctor relationship
2001	Liberalisation of the pharmacy market	Increase availability of pharmacies and medicines
2001	Individual plan	A tool to improve coordination of patients in need of long-term care services
2002	Reorganization of central government	Increase the efficiency and the coordination of national central bodies
2002	The hospital reform	Improve specialist health care services by reorganization and change of ownership
2003	A Broad Policy for Public Health, White Paper	Increase and strengthen public health
2004	Substance abuse treatment reform	Strengthen the treatment and accessibility to specialist health care for substance abusers

into account. In 1988 the Municipalities Health Care Act was further expanded when the responsibility of the counties' nursing homes was transferred to the municipalities.

Research at the end of the 1980s showed that most of those goals had been achieved, and that health and social services had been strengthened during the five years following reform, in terms of a relative bigger growth than other municipality services. Resources for preventive work had grown faster than other services; however, resources for elective medical services grew faster. This reform did not fulfil its objective to improve the allocation of health care personnel.

The HVPU reform (1992)

This reform was aimed at downsizing institutions for people with developmental disabilities. Throughout the 1970s and 1980s as larger institutions were downsized and smaller and more attractive institutions were built, criticism of institutional care became louder. Cases of abuse were identified in the media and the Union of Parents of persons with intellectual disabilities and growing numbers of policy-makers were raising questions about the quality of the residential care provided by the county-level Public Health Service for People with Developmental Disabilities.

The White Paper prepared for parliament based on the Royal Commission (NOU 1985:34) indicated that the committee did not see how the institutional system could be reformed and thereby achieve national goals. It emphasized that there was decreasing demand for special institutional services despite the growing number of people with developmental disabilities. It was further emphasized that as municipalities accepted responsibility for services, it was important to avoid the development of special care systems that might weaken the quality of services that at the time being were provided.

A key part of the Norwegian reform is about the guidelines on housing. It ensures that all people with developmental disabilities can rent or own the apartment or houses in which they live in their own names, and that their rent is paid from their social security benefits or earnings. The act provides special loans to individuals for this purpose. In addition, a special financial programme called Norwegian Housing Bank was required to provide loans to the municipalities for creating new housing needed. It was further provided that people with developmental disabilities would own everything in their apartments. They would pay for food, clothing, electricity, travel, and fees associated with their recreation/leisure activities from their own income. The municipality in turn would be responsible for assisting people in their homes, their places of work and in their recreation or leisure activities, where necessary, with help from skilled support providers. In order for municipalities to be able to meet these responsibilities, Norway had to expand and improve its programmes for educating those people who would provide that support at the municipality level.

Ultimately, the goal of this reform was to allow people with developmental disabilities to live like their fellow citizens, as far as is possible. Normalizing lives, including giving people back power over their own lives are still key challenges in the work for, and with, people with developmental disabilities.

Activity-based funding based on the DRG system (1997)

In June 1997, Norway introduced activity-based funding based on the DRG system. According to St. meld nr 5 (2003–2004) the introduction of activity-based funding was followed by a substantial increase in the number of cases treated and a reduction in waiting times. The system includes approximately 500 different hospital treatments, day surgery and some day medical procedures. It also includes births at delivery rooms and patients who are treated at hospitals abroad due to capacity problems in the domestic hospitals. This system does not include outpatient treatments where there are special reimbursement rates from the NIS, patients who pay themselves (for instance, foreign patients) and mental hospitals.

DRG weights are equal for all hospitals irrespective of cost structure, case mix and the type of hospital. A current national set of cost weights is estimated on the basis of costs in selected hospitals. The price of a DRG point is equal throughout the country and hence also reimbursement is equal. But the regional health authorities are allowed to change these reimbursement rates to their health enterprises. The share between block funding and activity-based funding has not yet found its “gold standard”. For example, the activity-based funding was decreased from 60% in 2003 to 40% in the 2004 budget and then back again to 60% in the 2005 budget, and then again back to 40% in the 2006 budget.

Action plan for the elderly (1998–2001)

The 4-year (1998–2001) action plan for the elderly set out objectives for the development of local nursing and care services. The plan entailed the use of central government funds to achieve these objectives. The core aims of the action plan were:

- to provide nursing and care services that ensure the elderly a secure and, to the maximum possible extent, worthy and independent life;
- to enable elderly persons to live in their own home as long as possible;
- to provide sufficient capacity to guarantee the availability of services whenever and wherever they are needed.

The results of this action plan were presented in 2002 in the White Paper no. 31 (2001–2002). Even though there are still significant differences between the municipalities, the action plan resulted in an improved situation in this field in those municipalities where coverage was poor, and created more equality in service supply among the municipalities in general. When the action plan is finally complete (some housing facilities are still under construction), then the complete frameworks will be in place, and more focus can be placed on

the content and quality of the services. The services capacity has also been strengthened, measured in man years for social care workers. During the action plan period the staff coverage increased from 43 to 46 man years per 100 inhabitants of 80 years and over. Following St.meld nr 45 (2002–2003), the government aims to improve the quality of nursing care in the municipalities. In particular, the government aims to increase medical help to nursing homes and strengthen geriatric medicine.

Escalation plan for mental health (1999–2008)

White paper no. 25 (1996–1997) *Openness and comprehensiveness* identified some weaknesses in mental health services: too weak preventive measures, insufficient number of municipal services, limited access to specialized service, too-short inpatient stays and lack of monitoring after patient discharges.

The Norwegian parliament adopted an eight-year (1999–2006) action plan for mental health (St.prp. nr 63, 1997–1998) in 1999. Important overall targets in the programme are a major expansion and reorganization of mental health services. The main areas for improvement are:

- strengthening the user's position and emphasizing public information
- strengthening the municipal services (especially prevention and early intervention)
- expanding and restructuring of the services for adults (e.g. Community Mental Health Centres (CMHC) (Distriktpsykiatriskesentre, DPS))
- expanding mental health services for children and adolescents
- improving labour market services
- stimulating education and research.

The plan was followed by an earmarked investment grant of about Nkr 6300 million and running expenses of about Nkr 4600 million. The National Mental Health Programme advocates decentralization and a greater integration of the services accessed by the mentally ill. At the local authority level, this involves integration of its welfare services, as well as close cooperation with CMHCs and psychiatric hospitals. This new programme also acknowledges the vital importance of putting in place a follow-up and general support apparatus to address the needs of psychiatric patients following their discharge from hospitals.

This escalation plan should have lasted from 1999 to 2006, but as the government saw that some measurements were as yet unfulfilled, it extended the plan for a further two years (until 2008). Evaluation reports revealed

considerable variation in the municipalities' planned work for this escalation plan outlined in the legislation (St.prp nr 1, 2003–2004).

The government also has a strategic action plan for mental health in children and young people called “Cooperation on mental health” from 2003. The action plan is a joint cooperation between the Ministries of Health, Children and Family Affairs, Justice and Police, Local Government and Regional Development, Culture and Church Affairs, Education and Research and Social Affairs. The action plan includes a complete presentation on how the government will strengthen and develop efforts to improve the mental health of children and young people. The focus of the action plan is health promotion, and it outlines the strategies to provide resources for young people so that they can define their own problems in a way that is comprehensible and manageable. The action plan focuses on the importance of a healthy neighbourhood, and on tackling the situations of those who already have mental health problems.

New health legislations (2001)¹⁵

In 1999 four new and important acts relating to health were adopted in Norway: The Specialized Health Services Act, the Health Care Personnel Act, the Patients' Rights Act and the Mental Health Care Act. These four Acts, with 40 regulations, came into force in 2001.

The Specialist Health Care Act stipulates that the state is responsible for the provision of specialized health care, and that the health authorities are responsible for providing specialized health services, including medical laboratory services, radiological services, emergency readiness and on-call services and ambulance services (by air, car and boat) for citizens with a permanent address or people who live in the region. The regional health authorities also have a duty to provide assistance in the case of accidents or other emergency situations that might endanger health.

The Health Care Personnel Act regulates 27 defined personnel groups, including physicians, nurses, dentists, psychologists, midwives, pharmacists and ambulance personnel. Its purpose is threefold:

1. to contribute to the safety of patients,
2. to contribute to the quality of health services,
3. to contribute to public confidence in health care personnel and in health care services.

¹⁵ Recommended reading on Norwegian health legislation: *Health Legislation in Norway*, edited by Olav Molven, 2002

The act on specialized health care and the act relating to health care personnel can be characterized mainly as a modernization of already existing regulations and concern the duties and obligations of providers and suppliers of health services.

The Patients' Rights Act is the first of its kind in Norway. It is partly a simplification and consolidation of already existing legislation, and partly an implementation of new rights. The main purpose of the act is to contribute to ensure that the population has equal access to good quality health care by granting patients' rights in their relations with the health service. The provisions of the act contributes to the promotion of that relationship based on trust between the patient and the health service, while at the same time having respect for the individual patient's life, integrity and human worth.

In summary, the Patients' Rights Act gives the patient the following:

- the right to necessary health care (including the right to evaluation within 30 days, re-evaluation and the right to choose a hospital);
- the right to participation and information;
- the right to consent to health care;
- the right to access to medical records;
- special rights relating to children;
- the right to complain;
- the right to assistance from the Patients' Ombudsman.

The Mental Health Care Act integrates the Patients' Rights Act, regulating procedures and conditions with regard to the establishment and implementation of voluntary and compulsory treatment for mentally-ill patients. It also sets out rules concerning inspection and reconsideration of administrative decisions made by mental health services.

Regular General Practitioners scheme (2001)

A bill on the list system for general practitioners was presented to parliament in September 1999 and approved in spring 2000. The aim of this bill was to reform the primary health care system so that individuals could consult their personal physician when they needed medical care. The new system, which was implemented nationally in January 2001, is based on:

- a registration system through which citizens sign on to the list of the physician whom they choose to be their general practitioner;
- the basic principle that everyone can choose whether they want to participate in the system or not;

- patients' right to choose another physician as their general practitioner (no more than twice a year) and the right to a second opinion by another general practitioner.

The aim of the reform was to improve the quality of, and access to, primary health care services. The intention was to contribute to continuity of care and to improve the patient–physician relationship especially for those people who need frequent and/or comprehensive medical service, such as the elderly. As every inhabitant was given the opportunity to have a regular GP under the list system, the municipalities had to meet this obligation by signing a sufficient number of contracts with GPs. According to the contract GPs must give priority to the patients on their list. The reform also defined the responsibilities of GPs. It was hoped that the list system will lead to better planning, organization and understanding of the practice and contribute to better coordination between various levels of the system. The NIS is responsible for managing the list system. This reform was designed based on the Danish GPs model.

The reform had two main elements. First, it introduced major changes in the way GPs were organized and how they were paid. GPs are responsible for planning and coordinating individualized preventive work, as well as carrying out examinations and treatment for the patients on their lists, and for keeping their patients' medical records up to date. Personal GPs practising full time may be required to have up to 1500 persons on their list (300 per day of practice), but all GPs have the right to argue for a shorter list. Having a personal GP is supposed to enhance the access and quality of services by creating a more stable physician–patient relationship to prevent 'physician shopping' in the cities and it is hoped that this will, therefore, reduce costs and improve working relations between primary and secondary care.

Second, this reform also has a new model for employing GPs, based on contracted physicians in private practice. Whereas many GPs previously practised in publicly-owned facilities, most will now own or rent their own facilities. In accordance with the new organizational model, many Norwegian GPs have been transformed from public employees into self-employed contractors. The terms and conditions of individual contracts are negotiated locally, but the main aspects are regulated by national standards (with regard to remuneration, size and composition of patient lists, and duties of patients, among other things). This change is in line with the new public management philosophy, as it implies a partial privatization of enterprises that previously were publicly owned and run.

In Norway, the personal physician system encompasses a new model for reimbursing GPs, whose salaries have been replaced by a mix of capitation and fee-for-service. The remuneration has three elements:

1. per capita payment from the municipality for every registered patient;
2. fee-for-service reimbursement from the state for each consultation, with different rates for different procedures;
3. a co-payment from patients for each consultation, with different rates for different types of consultations.

According to the Ministry of Health and Care Services, the GP scheme is functioning well, with 98% of the population having a regular GP. The share of “very satisfied” patients has risen from 32% in 2000 to 44% in 2004. Two-thirds of the GPs are satisfied with the scheme, and 35% are more satisfied with their working conditions now than before the introduction of the scheme. As mentioned previously, 99.5% of the population participates in the regular GP scheme, while 21 000 persons (0.5%) have chosen to remain outside.

Individual plan for long-term care services (2001)

Everyone who needs long-term and coordinated services has, since 1 July 2001, had the right to receive an individual treatment plan. The right to an individual plan is granted by the Act on Patients’ Rights which was adopted in 1999. The individual plan contributes to active user participation, increased safety, clarified responsibilities and secure coordination and cooperation between the public administration and the user and his or her next of kin. The individual plan allows for services to be adjusted to the person’s individual needs, preferences and objectives. The duty to develop an individual plan is spelt out in the Municipalities Health Care Act, the Specialist Health Care Act, and Mental Health Care Act, and thereby promises a broad coverage.

Liberalization of the pharmaceutical market (2001)

The main problems concerning the distribution of pharmaceuticals in Norway was the inadequacy of the retail network, the virtual absence of competition in areas such as service differentiation and operating hours, and the associated high retail margins. The situation reflected the strict regulation of the retail market, implying high entry barriers for pharmacies, including a requirement for the owner to be a pharmacist, and rules concerning the maximum number of outlets per capita and per municipality.

Two Royal Commissions (NOU 1997:6 and NOU 1997:7) form the background for the recent reforms in the pharmaceutical market. Their proposals were to liberalize the retail market, allowing free establishment of new pharmacies and ownership of pharmacies by non-pharmacists in order to increase the number of outlets.

The liberalization of the pharmaceutical market started in 2001 with a new Pharmacy Act allowing greater freedom in the establishment of pharmacies and in their ownership. This was followed by the right for pharmacies to change the physicians' prescription to another brand with the same active substances according to the Norwegian Medical Agency's list. Further, in autumn 2003, it became possible to sell some non-prescription, over-the-counter (OTC) drugs in retail outlets such as grocery shops and petrol stations. The liberalization of the pharmaceutical market has led to an increase in the number of pharmacies: a 30% increase from February 2001 (371 pharmacies) to March 2003 (481 pharmacies). Another outcome was that numerous previously independent pharmacies were replaced by three major integrated chains (for both the retail and wholesaler levels), controlling nearly 90% of the market.

Dalen (2003) showed that the pharmacy chains to a large degree compete on location and quality, but not on price. The growth in the number of pharmacies implies strong competition on location. There are still considerable price differences between generics and original brands, and this indicates that the generic competition seems not to have been exhausted by the Pharmacy Act of 2000.

The reforms have not changed the basic features of the pharmaceutical market. The physicians are prescribing the pharmaceuticals, and the state is still functioning as the largest third-party payer and the only approver of pharmaceutical products.

The act permitted the vertical integration of pharmacy chains owned by wholesaling companies (Anell and Hjelmgren 2002). As of 2006, three integrated vertical chains dominate the Norwegian pharmacy market.

The medical overseas project (2001–2004)

In November 2000, parliament granted Nkr 1 billion to purchase medical treatment overseas. The responsibility for organizing and managing the medical overseas project was given to the NIS. Contracts were set up with some 15 hospitals in Sweden, Denmark, Germany and France, who were selected based on the criteria of quality, similarity of treatment and experiences in Norwegian hospitals. The project started in January 2001, and by November 2001 around 4000 patients had received treatment abroad with a target of 5500 for that year. A wide range of specialties were chosen. The majority of patients were treated for orthopaedic, surgical and otolaryngology disorders, while, for example, there were few patients with ophthalmology and gynaecology disorders.

Parliament's arguments for setting up this arrangement were threefold: unacceptably long waiting times for hospital treatment; insufficient capacity

in Norwegian hospitals, including lack of staff, especially of nurses; and the belief that direct use of the same resources inside the Norwegian health care systems would generate negative macroeconomic consequences while medical treatment overseas was expected to have weak or absent domestic economic effects (Botten et al 2003). It was also believed that cooperation with foreign hospitals would force Norwegian hospitals to visualize their own available capacity, and provide an insight into the different management and treatments models. Sceptics warned of the risk of infections at foreign hospitals and thought that this arrangement would export activity that could otherwise have increased the medical expertise in Norway. In addition, other critics (which included the medical profession) claimed that the Norwegian hospital sector would be able to increase its capacity in a short time and that the resources should have been used in the country. Private agencies in Norway claimed they could provide an alternative. Botten et al (2003) found no incidence of infections, but concluded that the Norwegian hospitals could have increased capacity with an increase in recruitments. They also concluded that the medical treatment overseas project was rather expensive, and that some treatments overseas competed with domestic services, in particular, complicated procedures for the patients with heart disease.

As of January 2003, the NIS reported that Nkr 600 million had been used to treat 10 000 patients. The project was put in place for the fiscal year 2004, when it was included in the Patients' Rights Act. If a patient does not get the necessary medical treatment within a determined time, he or she may receive medical treatment abroad or at a private hospital. Supplementary funds were transferred to the regional health authorities as part of their "provide for" responsibility (St.prp. nr 1, 2003–2004), in accordance with the recommendations from NOU 2003:1.

Reorganization of central government (2002)

In 2002 the central governments' health service administration was reorganized. Over the years many smaller administrative bodies with specific purposes had been established, and many of these have been part of larger organizations since 2002.

The Ministry of Health and the Ministry of Social Affairs were established when the Ministry of Health and Social Affairs was divided. Under the previous administration there were two ministers, for health and for social affairs. Later the Ministry of Health was given new tasks and renamed the Ministry of Health and Care Services, further the Ministry of Social Affairs merged with the Ministry of Administration and Labour and was renamed the Ministry of Labour and Social Inclusion.

In 2002, two new agencies were set up: The Norwegian Directorate for Health and Social Affairs and the Norwegian Institute of Public Health. The directorate included several smaller organizations that, prior to the reform, were independent and run directly from the Ministry of Health, together with personnel from the Ministry of Health and Social Affairs, the Board of Health, etc. The directorate is responsible for the practical organization and implementation of many government undertakings in the health care sector and acts as adviser to the Ministry of Health and Care Services.

The Norwegian Institute of Public Health is a merger of the National Institute of Public Health, National Health Screening Service, the Medical Birth Registry in Bergen and the Department of Drug Consumption Statistics and Methodology from the Norwegian Medical Depot. The staff have also been supplemented with employees from the Norwegian Board of Health and the Ministry of Social Affairs and Health. The Norwegian Institute of Public Health has therefore numerous responsibilities related to public health.

Minor changes in 2002 included the establishment of the Norwegian Medicines Agency from the former Norwegian Medicines Control Authority, the main section of the department for pharmacies and pharmaceuticals in the Board of Health and parts of the national insurance administration. The objective is for better organization of the resources in the pharmaceutical area.

The Board of Health was established in 1994 (a transforming of the Directorate for Health, an organization that lasted from 1945 to 1994), but it was not until 2002 that the Norwegian Board of Health became an independent supervision agency, when many advisory tasks were transferred to the Norwegian Directorate for Health and Social Affairs.¹⁶

The reorganization reform is still in its early stages and the division of the responsibilities between the organizations involved is still not completely finalized.

The hospital reform (2002)

The hospital reform is a new experiment in Norway, having no real comparison with other countries. Scandinavian welfare systems often imitate each other, and as a result similar solutions to welfare challenges can be seen in neighbouring countries, such as Denmark and Sweden. However, Norway has followed a different path from its neighbours with regard to organization of the hospitals. Even though this reform is often called a hospital reform, it also includes

¹⁶ Source: Geir Sverre Braut.

most county municipal specialist health services – within both somatic and psychiatric health care and the ambulance service. The reform consists of three main strategies. First, the ownership of the hospitals was transferred to the central government sector, thereby placing responsibility with a single owner. Second, the hospitals are organized as enterprises. This means that they are separate legal entities and thus not an integral part of the central government administration, although ownership still is public. Principal health policy objectives and frameworks are determined by central government and form the basis for management of the enterprises. Third, the day-to-day running of the enterprises is clearly the responsibility of the general manager and the executive board. In this way the reform is also about decentralization of the management process. It is hoped that through decentralization it will be possible to achieve less bureaucracy, improved management and enhanced user information.

The takeover of responsibility for all hospitals by central government breaks with a tradition of more than 30 years, of hospitals being owned and run by the counties. (Norway is divided into 19 counties, each with an average of 240 000 inhabitants.) The counties were assigned responsibility for institutional health services with the terms of the Hospital Act on 1 January 1970.

The health enterprises are independent legal entities with their own responsibilities as employers. They have an executive board and a general management with clear powers of authority and are owned by the state. The Ministry of Health and Care Services, represented by the minister, is responsible for overall general management but there is extensive delegation to the underlying enterprises. In the light of the debate that has taken place in Norway, there are good reasons to clarify what the reform means in practice. It does not mean privatization – the hospitals continue to be owned by central government. Management of hospitals may not be transferred to private ownership unless a decision to do so has been reached by the Norwegian Parliament. The Norwegian state is responsible for the health enterprises' commitments – this means that the health enterprises cannot go bankrupt. It is too early to evaluate this reform, but preliminary results of the hospital reform point to at least two positive outcomes. First, it is reasonable to believe that real waiting times have come down. Second, the introduction of more clinicians into management structures has been observed, together with the strengthening of unified leadership arrangements, which can be related to increased attention to the quality issues.

The structure of the five regional health authorities and health enterprises is a new concept in the Norwegian public administration and it highlights issues that need to be considered in relation to this reform, for example, the future existence of regional enterprises, the role of the Ministry of Health and Care Services with regard to the ownership and steering of the specialist health

services, and the rationale for central state administration to have such a large administrative responsibility. In addition, there have been discussions about the establishment of a separate governmental body for the central ownership and steering of the health enterprises and the future development of health enterprises. For example, it is not clear whether they are going to be like ordinary, profit-making enterprises, or whether they should be more like governmental agencies. These questions are difficult to answer, but already there appear to be some elements of private enterprises, where administrative personnel have been recruited from the private sector.

Substance abuse treatment reform (2004)

The number of heavy drug addicts has doubled during the past 10 years in Norway. It has been estimated that there were approximately 4000–5000 intravenous drug users in 1989, 9000–12 000 in 1999 and 10 500–14 000 in 2001. The main centre for drug abuse is Oslo, the capital city, and there are tendencies for this problem to spread throughout the country. Heroin is the main drug for injection. The number of overdose deaths was 256 in 1989 and 374 in 2000. The death rate for intravenous opiate abusers is 3%–4% (Bretteville-Jensen and Ødegård 1999).

The 2004 reform was aimed at improving health care services and securing treatment provision for substance abusers (that is, people with alcohol and drug addictions). This reform shifted the responsibility for substance abusers from the counties to the national level (regional health authorities), and these services became part of the specialist health care from 2004. The reform also meant that people with alcohol and drug addictions are regarded as patients whose rights are protected under the Patients' Rights Act. Previously, the only referrals to the counties' institution and specialists went through the municipalities' social services. Following this reform, regular GPs also have the opportunity to refer patients with alcohol and drug addictions to specialist health services.

Report *Prescriptions for a Healthier Norway* (2003)

In the White Paper no. 16 (2002–2003) *Prescriptions for a Healthier Norway: A Broad Policy for Public Health*, reference is made to the World Health Organization's report on world health published in 2002, which focuses on factors that increase the risk of poor health. Special emphasis is placed on the importance of lifestyle changes. The report states that ten risk factors are responsible for one-third of all premature deaths in the world. In the most industrialized countries, at least one-third of the disease burden results from five risk factors: tobacco, alcohol, high blood pressure, high cholesterol and obesity.

Obesity, high blood pressure and cholesterol are linked directly to physical inactivity and a diet containing too much fat, sugar and salt. Norway, too, faces major challenges as regards lifestyle and health according to this report.

The report to parliament focuses particular attention on the diet of children and young people and raises a number of issues that give cause for concern, such as infant and toddler nutrition, rickets and vitamin D deficiency, and school meals.

One of the results of this White Paper has been the introduction of a green prescription scheme in addition to the standard blue prescription reimbursed by the NIS. A key issue has always been the list of reimbursable medications, and the introduction of a greater number of pharmaceuticals on the market that are directed towards preventive care. However, lifestyle changes can be both a better and much cheaper way to improve health. The green prescription scheme is designed to encourage physicians to prescribe programmes for lifestyle change, such as change in nutrition and/or physical activity before prescribing drugs, where, of course, this is an appropriate medical option. Patients may be introduced to a programme, which they are expected to attend, and their GP follows this up. Physicians will receive a greater reimbursement from NIS, thus providing economic incentives to use the green prescription.

The Tobacco Law (2004)

Norway was among the first countries to introduce a total ban on tobacco advertising and promotion, including all indirect advertising. The law was enacted in 1975. The new amendments to the law were introduced in 1996 and were aiming to counteract the attempts by the industry to try to circumvent the ban.

Though not part of the European Union, Norway is, because of the EEA Agreement, bound by law to enact legal provisions to fulfil the requirements of Community legislation. Directive 2001/37/EC concerning the manufacture, sale and presentation of tobacco products has, therefore, been implemented in national legislation.

Following the passing of the Tobacco Law of 2004, smoking is banned at places where food and/or drinks are served and where these items will be consumed in the same facilities as of 1 June 2004. Places which were affected by the law were restaurants, cafés, discos, bars, pubs and so on. The main purpose of this bill was to protect employees and guests from passive smoking. Employees in restaurants and bars were the only group in Norway that had no effective legal protection from tobacco smoke at their workplaces. Municipalities maintain the supervision of the legislation on smoke-free restaurants.

7.2 Future developments

Ageing population

Norway, like most European countries, faces challenges associated with an increasing number of elderly people. The old-age dependency ratio (persons aged 65+/persons aged 20–64) for Norway was 25.7 in 2000, and it is expected to increase to 42.9 by 2040 according to the OECD. This figure is below the OECD average of 46 and also below the other Nordic countries except for Iceland. The Norwegian societies' future cost for this trend is based on the fulfilment of the three following scenarios as presented by the OECD. Additional years of life in very old age could in principle lead to any of three outcomes according to the OECD long-term care report:

- Elderly people may continue to become sick and disabled at the same ages as previously, leading to additional years of disability at the end of life.
- The extension of lifespan must at some point come to an end. Poor health and disability may appear at later ages on average, but end of life would be static; this would lead to a “compression of morbidity”. First propounded by Fries (1980), this thesis has been the subject of lively debate ever since.
- The third possibility is that both average lifespan and age of onset of poor health or disability would continue to extend, leading to deferral of disability. Whether the average length of years of disability would grow, decline or stay the same would depend on the relative rate of extension of both.

These issues also heralded future reforms in the current pension system by the pension committee (see NOU 2004:1). The overall goal is to reduce pension expenditures by 3–4% of mainland GDP in the long term. Current expenditure on old-age pensions under the NIS in Norway is low in comparison with other industrialized countries. However, it is expected to rise more steeply in Norway than in other European countries (NOU 2004:1). With regard to future health care costs, it is clear that the largest element of the health care budget will be devoted to the elderly. According to a survey from Sintef Helse (Samdata 2003), the elderly use more of the health resources today than ten years ago. It is believed that the costs of old age will become a matter of a political struggle, since the largest part of the social and health care system in Norway is tax based and managed by parliamentary decision-making. On the other hand, with its increasing petroleum fund, Norway should now be better placed to deal with the health care costs of an increasing elderly population than other countries.

In its declaration of 2005 (The Soria Moria Declaration 2005), the government expressed its intention to increase the number of man years worked in the care services by 10 000 by the end of 2009, implement national

standards for physician services in nursing homes, and increase resources to educate specialists in geriatric medicine. Further, the Ministry of Health and Care Services has announced the White Paper *Omsorg for fremtiden* during 2006, outlining the future form of nursing care in Norway.

Globalization and health

Globalization is a complex process made up of economic, social, cultural, political and technological components and has a significant impact upon health sector. The division between national and international health problems is being blurred due to globalization processes. At the same time, coordination among various sectors in order to protect and promote public health is becoming increasingly important at international as well as national levels. National measures are, therefore, becoming ever more dependent on international cooperation and international agreements.

Good health is conducive to economic development and helps to reduce poverty. This leads to improvement in children's learning abilities, positive demographic change, higher productivity in the workplace, reduction in household expenses due to sickness, greater savings and thus greater investment. The WHO report shows that the global economic returns on investments in health are substantial (WHO Commission for Macroeconomics and Health 2001). The gains from health-promotion measures are three times as high as the outlay. Three of the United Nations' development targets for the millennium are health targets. Norway has committed itself, along with other countries and organizations, to work towards attaining these targets, with the objective of improving health and strengthening the health services in poor countries. This will also help to strengthen the defence against communicable diseases and drug-resistant bacteria in Norway. In this way, the effect of political decisions will be intensified in both areas (St.meld. nr 16 2002–2003).

EU regulation and Norwegian legislation

Norway is not a member of the European Union but is part of the European market via the European Economic Agreement. As long as there is a common European market, the issue of health as a commodity and service will sooner or later influence states in different ways, and Norway is no exception.

The case with regard to alcohol illustrates an area where international regulations do not always coincide with national policies, as the following example shows:

A key element in Norwegian alcohol policy has been to remove private profit from sales of wine, spirits and strong beer. As a result, Vinmonopolet is wholly

owned by the state and is an important instrument for making wine, spirits and strong beer available in a form that is acceptable for society. The European Union has overridden the Norwegian regulations following a decision by the EFTA Surveillance Authority (ESA) Court in 2002. The EFTA Surveillance Authority took Norway to court in 2000 demanding the introduction of equal conditions for the selling of beer and other drinks containing between 2.5% and 4.75% volume of alcohol. The EFTA Surveillance Authority Court made it clear that Norway's regulation was inconsistent with the EEA agreement, and a court ruling allowed the selling of alcopops outside the Vinmonopolet, even though the government disagreed.

Integration and cooperation of different levels of health and social care

Integration of health care services is considered to be one of the most important problems facing most European countries. There is growing concern among decision-makers in Norway that increased specialization and complicated sets of rules in health and social sectors will lead to lack of continuity of care and reduced quality of services. Currently there are no specific programmes for integrated care in Norway, but there have been some positive trends towards achieving it. For instance, the regular GP scheme goes some way towards establishing a permanent relationship with one physician over a long period, which makes it possible to obtain a more holistic view of the patient. One further initiative towards integrated care is incorporated into the individual plan, which outlines and specifies health and social services for patients with long-term care needs. In addition, the Royal Commission (NOU 2005:3) tried to answer the need to strengthen the integration and cooperation process in the two-tiered health care system.

A new employment and welfare administration (NAV)

In 2005, there were three agencies: the Labour Market Administration (Aetat), the National Insurance Service (Trygdeetaten) and the Municipal Social Welfare Service (Sosialkontoret) involved in conducting welfare services for the population. In order to meet users' overall needs for assistance a joint front-line service will be established, with a municipal-central government employment and welfare office in each municipality. This office will be providing a gateway to the employment and welfare services and will be perceived by the users as a single entity. It will offer a range of services for the unemployed and enterprises, people on sick leave, disability pensioners, and people who receive financial social assistance, pensions and family benefits. It is expected that the formal

establishment of the new agency should be possible from the second half of 2006, and it is expected that the front-line service will, essentially, be in place throughout the county by 2010.

Further development of the payment system

The Royal Commission (NOU 2003:1) and the White Paper that followed (St. meld nr 5 2003–2004) outlined further reforms with regard to the financing system. The policy paper mentioned above recommended the development of patient classification systems based on hospital stays, or activity in groups that are as far as possible homogeneous, with regard to medical as well as cost criteria. This would make it possible to obtain comparative information among the hospitals about the composition of patients, activity and use of resource. The best-known patient classification system is the DRG system, and is currently used in Norwegian hospitals. The development of patient classification systems is important in gaining better steering information and in developing the activity-based funding scheme to include patients that are currently not included. This will make the present financing model (with activity-based funding and block grants) less exposed to unwanted distortions in the service provision.

The Ministry of Health and Care Services intends to start developing patient classification systems in the new fields of specialized health services, for example, psychiatry, substance abuse care, rehabilitation, highly specialized somatic services and a unified system for laboratory tests. A patient classification system for psychiatry is a high priority. The development of this system is time consuming, and there is a plan to introduce a new system in about three to five years starting in 2005. A joint patient classification system for all types of somatic treatment, including ambulatory care, was introduced in 2006 and the plan is to introduce an extended version of the activity-based funding in 2007. Currently the Norwegian Directorate for Health and Social Affairs is leading the project of developing the future payment system in specialist health care.

A dental health care reform

According to the government's findings in 2005, people with chronic illnesses and low income often have poor dental health and are likely to face relatively large expenses for dental treatment. The government wants to start developing the legislation on publicly funded dental health care services for specific groups in the population. A Royal Commission (NOU 2005:11) regarding dental health care will probably formulate some of the contents in this forthcoming reform.

8 Assessment of the health system¹⁷

8.1 The stated objectives of the health system

The Norwegian health system has been going through a series of changes during the last few decades, making use of different approaches in the financing, organizing and providing of services. Primary, secondary and long-term health care have been exposed to continuous change and some radical reforms.

But the overriding goals of solidarity and equality as a basis for welfare have remained basically unchanged. The national goals have been to improve the level of health for the population and to distribute health care according to needs. Goals pertaining to the level of health are formulated as “more years with a good health for the population...”, “quality of life...” (St.meld. nr 16 2002–2003). Special focus on goals for health and health problems for particular groups (for example, neonatal, women, cancer patients, elderly and employees) are cited in numerous policy documents.

The distribution goals are formulated as an ambition to improve the aggregate health for the population and to reduce inequalities in health. The health policy is striving for a redistribution based on equality, justice and solidarity. Through a strong public and political consensus the main institutional strategy to meet the goals has been to offer universal coverage of high-quality health care services according to need, with equal access for equal needs regardless of gender, social background, personal economy and geography.

The normative aspects of the citizens’ rights for health care in Norway are expressed in the Patients’ Rights Act. This stipulates the principles of the

¹⁷ The contribution of Odd Arild Haugen to this section is gratefully acknowledged.

access to health care services and outlines the goal “to secure the population equal access to health care of good quality”. The law also sets limits for what falls inside the guarantee offered by the law: the citizen’s right is only valid if the patient has an expected benefit from the health service, and the costs are in proportion to the effect of the intervention. The law does not prioritize different diagnoses and/or health status. The principle of equality of access is supplied with a priority for interventions that affect health status or health improvement (Bringedal 2005).

After pronouncing the same rights for the same health problems it gives priority to the greater need and the possibility of health improvement. The health care system is based on the principle that health care services are supposed to be distributed according to needs. Health care has for the most part been provided by the public sector.

8.2 The distribution of the health system’s costs and benefits across the population

There are several sources of Norwegian care financing. It is estimated that different kinds of taxes cover about 85% of the total spending while the out-of-pocket payments come to about 15%.

Cost distribution and financing of health care

The financing of the health care system is for the most part covered by public money, estimated to constitute 85% of the overall expenses, while out-of-pocket money amounts to 15%. The aspect of the health financing system’s use of a system based on the ability to pay and the system’s effect on redistribution within the population is seen as a reflection of the general tax system. Use of progressive tax measures to attain a distributive effect is an important policy element in the political basis for the tax system. The degree of redistribution for the tax system as a whole could be indicated by the GINI factor, and shows results from 2001 of 0.243. However, there is, to our knowledge, no specified analysis of the redistribution effect of the specific financial sources for health care financing.

There are four main sources of financing of the public health care system and three of them are forms of taxes, i.e. direct taxes, NIS and indirect taxes. The biggest contributor to the financing of the health care system is through the direct tax system. Parliament sets the rate of tax centrally, which is proportional and based on a progressive wage and income structure according to general

political redistribution objectives. For the financing of health care this means that within the logic of the taxation system the contribution is based on the citizen's ability to pay.

The second important source of financing is the NIS, a social and health insurance system. The NIS finances outpatient services, pharmaceuticals and medical devices. The financing of this system consists of a set percentage of salaries with contribution from employers and employees. The fixed tariff contributes to redistribution of resources. The fund is not an insurance system drawing only on the contributions of employers and employees. Parliament grants substantial sums through the national budget every year. In this way the NIS is also based on direct tax money – and national income (e.g. profit from exploitation of oil).

The third source is through indirect taxation, for example, sales taxes, and is derived from a flat percentage on the price of goods or services. There is no link between this tariff and the relative income of the citizen and, therefore, it does not serve distributional goals.

The out-of-pocket payments, which constitute approximately 15% of the health system finance, are also based on a policy of distributional goals. For every budget year parliament sets a ceiling for individuals' co-payment for health care, e.g. it was NKr 1615 for adults in 2006. The strategy is to set a limit on the expenditure for services and pharmaceuticals. In 2003 the authorities issued 950 000 certificates exempting patients from co-payments in order to assure equity in terms of health care expenditure. In other words, the limiting of individual expenditure is not in itself an intentional goal, but the arrangement implies that access to health care services should not be limited by the ability to pay (Bringedal 2005). The expenditure ceiling is set at the same level for all adults. Co-payments increase in proportion to the use of services up to a certain level, and are not progressive with regard to income and wealth. Another aspect of this arrangement is that the services they pay for are not subject to prioritization as all expenses for co-payment count equally up to the limit.

For a prosperous country like Norway a co-payment limited upwards to NKr 1615 (2006) a year for adults does not seem to be a major barrier to people in need of medical services. Against this background the political and public debate over the co-payment system offers an interesting illustration of expectations, principles and practice on equity in Norwegian health care.

In a way, the mechanism may be seen as a scheme to reduce the users' costs. The underlying principle, however, is equal access to essential health care regardless of the individual's economic status (Bringedal 2005). This principle was important also from the experience that low income correlates with more frequent health problems.

There is limited evidence about the out-of-pocket scheme's effect on behaviour in seeking necessary medical advice. Limited evidence points to its possible medical effect and on the scheme's ability to reduce moral hazard.

Much of the debate focuses on the current co-payment scheme and the setting of the ceiling (Nkr 1615 in 2006). In addition to the co-payments there are out-of-pocket payments for pharmaceuticals (outside the blue prescription list), dentistry, physiotherapy, and many other services and devices that may add up to considerably higher sums for patients with long-term or chronic diseases. The discussion also centres around the debate on social equality and the total health care costs in a country that used to think about health care being free at the point of delivery, but where the out-of-pocket and co-payments for some groups have become barriers for access.

The health policy debate on this topic contains a wide spectrum of proposals, ranging from dropping the co-payment altogether to the possibility of making more extensive use of the general safety net administered by the municipalities to cover expenses for essential care, as suggested by politicians. Both options present certain problems. Co-payments have become a considerable source of financing of health service in the country over the years. The alternative of expanding the social security scheme (NIS) goes against the long-term Scandinavian tradition in tax financing. Means testing (inevitably brought up in social security cases) must be rejected as part of the decision to have free access to health care service, on the grounds that it may stigmatize particular groups of people (Holm et al 1999).

Dental health care is organized and financed in a different way. Services are divided between the public and private sectors. The public service finances legally required services for children and young people until the age of 18. Nineteen- and 20-year-olds may receive public services with a co-payment of 25%. Publicly covered services also include patients with long-term or chronic diseases who are resident in nursing homes, psychiatric institutions, disability institutions and in home care. The NIS will also cover expenses for dental surgery and periodontal disease. Most adult citizens, on the other hand, must pay the full cost of dental care from their own resources. There is no comprehensive information about the use of all these financial schemes. In addition, there is limited knowledge about people's views on prioritizing dental care, what constitutes essential dental service, and to what extent the financial scheme limits people's access to such services. A survey conducted in 2003 reports some access problems for dental service (Svalund 2005). The paper estimated that in 2003 6% of the adult population abstained seeking dental service for economic reasons, even if they felt they needed to. The access to dental care depends on the individual's economic status and implies that inhabitants with lower income have restricted access to dental services.

Distribution of health care

Distribution of health services presents a special challenge in the Norwegian health care system, due to the country's demographic and geographic situation. One of the key issues of the Municipalities Health Care Act (1982) was the distribution and recruitment of personnel in rural areas. At present, Norway faces a challenge in employing public dentists in some rural areas. Measured against physicians per capita in primary health care, there are more physicians in rural and scattered municipalities than in the urban areas, but one should keep in mind the long distance that people in the rural and scattered municipalities may need to travel in order to visit their physician. In addition, most of the major hospitals are situated in urban areas, and nearly all the tertiary-level hospitals are situated in cities, thereby necessitating extra travel time for patients living in rural areas. In order to balance these differences there is a large network of ambulance transportation by land, air and sea in use, especially for critical incidents. There is a correlation between the patients' residence and the use of tertiary-level services, i.e. persons living near the tertiary-level services were using them more often (NOU 2003: 1). In order to address this inequality work has been put in place to develop detailed DRGs for tertiary-level services. The regional health authorities' decision to shut down local hospitals led to a public outcry, leading central government to take action and rethink the future role of the local hospitals in Norway and prevent further downsizing of local hospitals (see St.prp. nr 1 2004–2005).

One study by Grøholt and Nordhagen (2002) based on data from about 10 000 children aged 2–17 in the Nordic countries in 1996 analysed the association between utilization of health services among children (consulting a physician or being hospitalized) and parental education. The use of GPs had no bearing on parental education in any of the Nordic countries. However, whereas the use of specialist services was associated with higher parental education, a higher proportion of children in poorly educated families were hospitalized.

Equity and justice values have been strongly embedded in the Norwegian culture since the Second World War. Norwegian statistics in health and social indicators were measured in average sizes without taking account of the fact that these indicators might mask large differences in health between rich and poor. Research during the 1990s found that the differences in health persist and in some areas were large even by European standards.

In Norway as in other western countries, ill-health, illness and premature mortality are inversely related to socioeconomic status. Current evidence can be summarized as follows (based on Dahl 2002):

1. Health inequalities apply to most age groups, with the exception of adolescents, and are most pronounced in the working age group.

2. Both men and women are affected by health inequalities, but men seem harder hit than women.
3. Health inequalities are related to a whole variety of socioeconomic indicators.
4. Health inequalities form a social gradient. Not only are the lowest groups worse off than those at the top, there is also a graded pattern: as one moves up the social scale, health improves step by step.
5. Health inequalities persist. Recent evidence shows an increase, at least in relative terms, rather than a decrease in health inequalities.
6. Health inequalities in Norway are not significantly smaller than in other European countries.

The health of the population is consistently improving, but at the same time inequalities in health increase due to social inequalities. This problem has recently received more attention from policy- and decision-makers.

8.3 Efficiency of resource allocation in health care

It is possible to distinguish both vertical and horizontal allocation in health care. Vertical allocation in this setting means the resource allocation between primary health care (represented by the municipalities) and specialist health care (represented by the regional health authorities or the state). Horizontal allocation means the allocation between different providers of health services at the same level (meaning the relationship between different municipalities).

Vertical resource allocation was mentioned in a Royal Commission (NOU 2005:3) and it explicitly points out: “Even though there seems to be professional and political agreement on the role of the primary health, it is possible to observe today a great gravitational force towards specialist health care regarding allocation of resources and attention. The Commission thinks the municipalities’ health care service (primary health) must be given more attention”. There is increasing specialization in the Norwegian health services. In addition, the commission stressed that new technology is not highly prioritized for certain patient groups, such as the elderly, those with chronic diseases and mental disorders, and drug and alcohol addicts.

Horizontal resource allocation is a challenge in Norway. It is important to stress the country’s demographic structure with a mix between urban and rural areas, and a scattered population. It is more expensive to run primary care facilities, such as school health stations, and emergency wards in rural areas

than in urban areas. This has to be considered in conjunction with the policy aim in Norway that health and social services should be equal everywhere. This means that the resource allocation and funding to rural municipalities must be diverse enough to meet those demands (as the differences in per capita spending for primary medical care showed). The income system to the municipalities has been changed many times since 1986. Most changes happened after the work of two royal commissions (NOU 1996:1, NOU 1997:8) at the end of the 1990s. Debates about the arguable benefits of municipalities levying company tax have been taking place. This taxation gives strong incentives to develop the industry. However, it may cause instability in the income base and result in greater differences between municipalities. As municipalities take on more tasks, the income components in the transfers from the state have to be changed, for instance since 1997 the income components to the municipalities regarding nursing care have been changed three times. Costs today are audited in accordance with a Royal Commission (NOU 2005:18).

Owing to the scattered population in Norway, there are similar income mechanisms for specialist health care. Regional Health Authority North gets a larger transfer from the state than other regional health authorities. There are increased transfers to rural health enterprises inside the health regions.

With regard to health care personnel, the biggest challenges occur in the area of nursing care for the elderly. It is expected that there will be a shortage of auxiliary care nurses in the municipalities in the years to up to 2020. However, it is not easy to estimate the demand for health care services. With surplus on the national budget, and an estimated petroleum fund of more than Nkr 1000 billion, there will certainly be pressure to spend more money on health care services.

8.4 Technical efficiency in the production of health care

Currently, the output of the Norwegian health care system is at its maximum in terms of the number of patients treated and the number of health professionals employed and money spent. Norway spends 65% more on health care on average for every citizen compared to the OECD countries. Compared to neighbouring Sweden, Norway spends 45% more per capita in this sector. Eighty-five per cent of the expenses are covered by public money – the largest share of public money (OECD Health Database 2004). Further, comparing the health expenditures per capita adjusted for PPP, Norway is third, behind the United States and Switzerland in 2004, but way in front of neighbouring Sweden, Denmark and

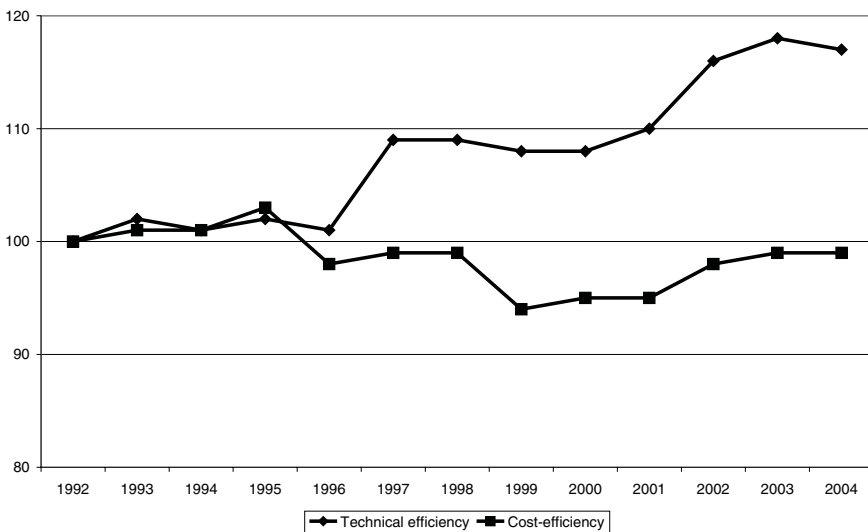
Finland. These data naturally raise the question of efficiency in the Norwegian health care system.

Though it is difficult to point exactly to the level of efficiency in a health care system, we can draw attention to reports about technical efficiency and cost–efficiency for hospitals (Samdata 2004). Figure 8.1 shows the development in respect of cost–efficiency and technical efficiency in specialist health care for the period 1992–2003. The reference year is 1992, and the numbers/digits are index values.

With regard to the development of the hospital sector in 2004 the hospitals showed a higher production for their input factors than in 1992. The cost of use for each input factor, however, has increased considerably. To put it simply, one got less for every krone spent on health in Norwegian hospitals in 2004 than in 1992. The increase in efficiency was significant following hospital reform (St. prp nr 1, 2004–2005). The efficiency measured against the number of patients treated per man labour year (technical efficiency) has increased by 3.5%–4% from 2001 to 2004, and cost–efficiency has improved (by 1.5%–2%), resulting in greater value for money in the same period.

The analysis of the relationship between efficiency and financing (Biørn et al 2002) showed that the introduction of activity-based funding in 1997 resulted in immediate increased technical efficiency, but at the same time increased total costs. The interpretation is that the activity-based funding resulted in larger

Fig. 8.1 The development in technical efficiency and cost–efficiency in hospitals from 1992 to 2004 (1992=100)



Source: Samdata 2005.

growth in activity than in resource achievement, so this growth was expensive. The hospitals had little knowledge about their own costs, and together with soft budget frameworks this resulted in a strong and partly unexpected growth (Slåttebrekk and Aarseth 2003).

Efficiency measures implemented in the area of mental health show that the number of patient discharges per man year increased by 10% from 2001 to 2003, while the number of ambulatory care consultations per man labour year increased by 18% in the same period.

Regarding nursing care, the number of man labour years has increased more than the number of patients receiving care. This applies both in nursing homes and home-based care. A possible explanation for this trend is higher demand by consumers.

There have been a number of substitution policies especially with regard to pharmaceuticals. Generic substitution was introduced in 2001 in order to limit growth in pharmaceutical spending. In 2005, the so-called step-price system was introduced offering a potential saving of Nkr 400 million per year. However, other substitution policies have not been widely used; for instance, efforts to substitute dentist's procedures with dental assistants have been met by negative reactions.

8.5 Accountability of payers and providers

Accountability and transparency are important dimensions in the Norwegian health care system. The principles of accountability differ in the various parts of the system, depending on their links with the political system.

Primary health care and public health are incorporated within the municipal level. Politicians are accountable to the local citizens through elections. Public auditors control budgets and other fiscal matters. The municipal system is also accountable to central government for following policies, routines and regulations. Within this decentralized system there is, of course, a large degree of discretion enjoyed by those responsible for carrying it out locally, and that makes accountability in certain areas thinner.

The general practitioners and private specialists constitute large groups of liberal professionals working within general contracts and with remunerations from the NIS subject to auditing. The GPs are also accountable to the national and county supervision authorities. This arrangement may cause them to feel more accountable to their patients and subject to peer review, but are less likely to be accountable upwards in efficiency or effectiveness.

The major reform in secondary health care in 2002 was somehow a paradoxical reform in the sense that responsibility for secondary health care was transferred from the county level to the state level and then executive authority was delegated to five regional health authorities with professional boards. One of the main political reasons for this reorganization was the focus on responsibility and accountability. Before hospital reform, counties owned the hospitals and were responsible for their management, but the state became increasingly responsible for the finance. Consequently, accountability links were insufficiently clear. The reform made it a major task to clear up the accountability issue with regard to financial management as well as the management of efficiency and effectiveness.

Politically and constitutionally, the relationship between parliament and the Minister of Health is clear. Parliament makes the policies, organizational and fiscal decisions, and the Minister of Health and Care Services gives instructions and delegates power to the regional authorities that in turn delegate and instruct the providers (the hospitals). In this way, the delegation downwards is clear. So is the corresponding accountability upwards from the minister to parliament. The minister is accountable constitutionally to parliament, for everything that happens in the public health sector, but with the understanding that parliament should not interfere with the executive role of the regional boards.

However, accountability upwards has not proved to be so clear in practice from the providers to the political institutions when it comes to financial management of budgets. Traditionally, budget management has been one of the accountability criteria. Despite the increased budgets, activity and growth have led to higher budget deficits than ever before. The reform is only three years old and it needs to be seen whether this will result in improved accountability and tackle the “soft budgeting” issue. Another intense debate should be mentioned. There are claims that the professional boards, instead of boards managed by local politicians, have resulted in a democratic deficit or lack of accountability to the local population.

So far, professional accountability within the clinical settings has not been given much attention. Supervision authorities look into clinical practice, most often when clinical mistakes are claimed. In a country that has spent so much time focusing on prioritizing within health care, it could have been expected that accountability for its practice in prioritizing would be given more attention. Major consequences stem from decisions made about prioritizing both nationally and locally. It is pointed out that there is little openness around these kinds of decisions, and that the country lacks strong institutions to offer rationality and openness.

8.6 The contribution of the health system to health improvement

By international standards, the health status in Norway is very good. However, it is not easy to measure the health sector's contribution to the population's general health. On one side, the health care sector functions as an insurance for unfortunate actions and accidents, and the network of health care personnel, sick transportation and health institutions make it possible for all Norwegians to get help whether onshore, offshore, in urban or rural areas. This public health system undoubtedly functions as a very important safety net for the Norwegian population.

Vaccination programmes since the Second World War conducted by health care personnel throughout the country have undoubtedly strengthened immunity against illness, helped in the preventive fight against diseases, and eliminated many of the diseases that were severe, or fatal, in the pre-war period. Deaths from cardiovascular diseases have reached an all time low; the reason for this is probably to be found in better preventive care (better nutrition, fewer tobacco smokers, etc.) and better direct treatments (blood vessel surgery, pharmaceuticals, etc.). Accident prevention has been successful in Norway. Together with Sweden and the United Kingdom, Norway has the lowest rate of mortality due to traffic accidents in the world. This may, in some way, be explained by frequent road controls together with a low drink-drive limit.

In the year 2004, a newborn girl could expect to live to approximately 83 years while a boy could live approximately 78 years. Twenty years ago, these figures were respectively 78 years and 73 years. The major factor behind the improved life expectancy is better lifestyle; a significant effect for men in recent years is the decline in smoking.

Public health efforts to reduce the harmful effects of tobacco have been successful over the last 30 years. There has been a drop in the number of daily smokers from 52% in 1973 to 27% in 2003 for men, and from 30% to 25% for women in the same year. Some of the reasons were public health PR campaigns, high taxes on tobacco products (and thereby high prices) and a ban on tobacco. The consumption of alcohol was high after the Second World War, with a downward peak in the 1980s. During the 1990s to present, there has been an upward trend (especially among young people). Alcohol-related mortality is expected to rise, due to increased consumption.

Excess weight and obesity have become more common in all socioeconomic groups during the last 20 years, but on an international level the scale of

obesity in Norway is relatively low. The preventive part of the public health campaigns will probably be more intensified on the problem of obesity in the years to come and will include measures such as PR campaigns, work-related health programmes, and emphasis on the inclusion of vegetables and fruits in school meals.

9 Conclusions

The Norwegian health system is a tax-based system that covers all inhabitants. It is built on the principle of providing equal access to services for all inhabitants, regardless of their social and economic status, and location. To fulfil this aim, the structure is organized on three levels that mirror the political tiers: the central state, five health regions, and the 431 municipalities. Local governments draw on local taxes and a mixture of block grants and specific allocations (earmarked means) from the national government in order to cover their expenditure. In addition to funding, the central government also provides legislation and supervision to ensure that the services offered by local government comply with the national goals. The Norwegian decentralized health system was founded on democratic values, bringing the politics of health care closer to the users. The Norwegian health system incorporates a decentralized model of provision of welfare goods and services, which has a long tradition in Norway, and in this way seeks to encourage inhabitants to take part in local politics.

Recently Norway has been successfully implementing numerous reforms in primary and secondary health care, financing, mental and public health sectors, pharmaceuticals sector and others. Hospital reform in 2002 aimed to increase efficiency, improve management and enhance user information. It consisted of the three main strategies: hospitals were organized as enterprises/trusts; their ownership was transferred to the central government administration; and management of the hospitals was decentralized. Preliminary conclusions point to decreased waiting times and shorter waiting lists for a number of diagnoses, and increased interest in management issues among health care professionals.

The General Practitioner scheme introduced in 2001 gave citizens the opportunity to have a personal GP, and comprised two main elements: it changed the way GPs were organized and how they were paid. Many Norwegian GPs

who were previously public employees are now self-employed contractors. The terms and conditions of individual GPs' contracts are negotiated locally, but the main aspects are regulated by national standards. The second element aimed to enhance the access to, and the quality of, services by creating a more stable physician–patient relationship and to improve working relations between primary and secondary care. This reform has been a success not only in terms of the coverage of physicians geographically, but also with regard to improving their relationships with patients.

In 2001 a new law was passed allowing greater freedom in the establishment of pharmacies, which permitted the vertical integration of pharmacy chains owned by wholesale companies and allowed the pharmacies to change the physicians' prescriptions to another (e.g. generic) brand. This reform resulted in an increasing market share for generics. A more recent effort to regulate the pharmaceutical market is represented by the index price system: introduced in 2003, this allows the retailer to gain extra margins if a cheaper medicine is chosen instead of an expensive one.

In June 1997, Norway introduced the activity-based funding system for the somatic hospital-based health services based on the DRG system. This reform was followed by a substantial increase in the number of cases treated and a reduction in waiting times.

Mental health has been considered as a priority area in Norway and has undergone significant reforms in the early 2000s. The objectives of mental health reforms are to reduce the stigmatization of mental illnesses and restructure the system by giving greater responsibility to the municipalities. The reform has fulfilled its objectives so far and new mental health centres and the necessary support systems in the municipalities have been built.

A White Paper (St.meld. nr 16, 2002–2003) presented a broad public health policy for the years to come (partly based on the WHO 2002 report). The focus of this report was on key risk factors such as tobacco, lifestyle, alcohol abuse, drug addiction and obesity. Norway was among the first countries to introduce a total ban on tobacco advertising and promotion, including all indirect advertising. Numerous interventions to tackle alcohol and drug abuse in Norway have also been implemented.

Several preconditions for successful health policy in Norway can be listed. Norway's decision-making process has been consensus oriented. Most decisions have been made through negotiations with interest groups, with the medical association as one of the key players. Policy process could be characterized as combination of central command and control (defining the policy goals, monitoring the outcomes, etc.) and local freedom to choose the most suitable means (the “tight-loose” principle), and policy-making is separated from

implementation (the ‘steer, don’t row’ principle, in which politicians are more concerned with strategy and less with implementation). In addition, political commitment to assess the health system as a priority has been brought to the fore.

Despite successful health policy development in Norway some challenges need to be addressed in future.

In parallel with other countries, integration of health and social care services is currently one of the most important challenges in the Norwegian health sector and there have been a number of attempts to try to address this issue. During 2004–2005, two Royal Commissions were created in order to identify the means for improving coordination of different levels of health care, and cooperation between health and social sectors. In particular, this includes the elderly and people with disabilities, with complex diagnoses and chronic diseases, who are the intended beneficiaries of a stronger integration between health and social services.

The Ministry of Health and Care Services has started working on further improving financing systems and on developing patient classification systems based on hospital stays or activity groups, which should pay maximum attention to medical as well as cost criteria. This would require the gathering of comparative information from hospitals. The development of patient classification systems is important to enable better dissemination of information and an efficient financing system (activity-based funding scheme). This will make the present financing model (with activity-based funding and block grants) less subject to unwanted distortions in the patient services. A patient classification system for psychiatry has been perceived as priority; there is a plan to introduce a new system by the year 2009.

One of the challenges for the future is in achieving the optimum balance between the roles of different parts of the health care system, i.e. municipalities and the state. There have already been some trends in inter-municipality cooperation, e.g. agreements with regard to physicians’ emergency call services as a means of increasing cost-effectiveness.

Addressing persisting health inequalities in Norway has become a social priority. However, there is a general lack of evidence on efficient interventions to reduce these inequalities. Therefore, in future it will be important to make decisions about instruments and strategies to deal with this issue. Other challenges are interventions to reduce alcohol and drug abuse, especially among young people, problems related to an ageing population and its impact on the health care services, globalization in terms of potential pandemic disease, and information technology in the health sector.

Health care policy has been a political priority in Norway and the organizational structure of the health system allows inhabitants to be involved in the policy-making process. This commitment is demonstrated by recent and earlier health reforms. Experience from the Norwegian health system illustrates that it is possible to achieve these political and social goals.

10 Appendices

10.1 References¹⁸

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NOU: 9 (1999) *Livshjelp (Vital aid)*. Statens forvaltningstjeneste (Royal Commission).

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10.2 Useful web sites

Norwegian official webportal (Internettportalen www.norge.no): www.norge.no

Parliament (Stortinget): www.stortinget.no

Ministry of Health and Care Services (Helse- og omsorgsdepartementet): www.odin.dep.no/hod

Ministry of Labour and Social Inclusion (Arbeids- og inkluderingsdepartementet): www.odin.dep.no/aid

Ministry of Local Government and Regional development (Kommunal- og regionaldepartementet): www.odin.dep.no/krd

Ministry of Education and Research (Kunnskapsdepartementet): www.odin.dep.no/kd

Ministry of Finance (Finansdepartementet): www.odin.dep.no/fin

Ministry of Government Administration and Reform (Fornyings- og administrasjonsdepartementet): www.odin.dep.no/fad

Norwegian Directorate for Health and Social Affairs (Sosial- og helsedirektoratet): www.shdir.no

Norwegian Board of Health (Helsetilsynet): www.helsetilsynet.no

Norwegian Patient Register (Norsk pasientregister): www.npr.no

Norwegian System of Compensation to Patients (Norsk pasientskadeerstatning): www.npe.no

Norwegian Institute of Public Health (Folkehelseinstituttet): www.fhi.no

Norwegian Medicine Agency (Legemiddelverket): www.legemiddelverket.no

National Insurance Administration (Trygdeetaten): www.trygdeetaten.no

Norwegian Knowledge Centre for Health Services (Nasjonalt kunnskapssenter for helsetjenesten): www.kunnskapsenteret.no

Norwegian Labour Inspection Authority (Arbeidstilsynet): www.arbeidstilsynet.no

KS – Norwegian Association of Local and Regional Authorities (KS-kommunesektorens interesse- og arbeidsgiverorganisasjon): www.ks.no

Health Economics Research Programme at the University of Oslo – HERO (Helseøkonomisk Forskningsprogram ved Universitetet i Oslo – HERO): www.hero.uio.no

Programme for health economics in Bergen (Program for helseøkonomi i Bergen): <http://heb.rokkan.uib.no/>

Norwegian Public Safety Radio Project (Nytt digitalt nødnett): www.nodnett.dep.no

Norwegian Medical Association (Legeforeningen): www.legeforeningen.no

Statistics Norway (Statistisk Sentralbyrå): www.ssb.no

Norwegian Dental Association (Tannlegeforeningen): www.tannlegeforeningen.no

Norwegian Association of Pharmaceutical Manufacturers (Legemiddelindustriforeningen): www.lmi.no

Norwegian Nurse Association (Sykepleierforbundet): www.sykepleierforbundet.no

Norwegian Pharmacy Association (Norges Apotekerforening): www.apotek.no

The Office of the Auditor General (Riksrevisjonen): www.riksrevisjonen.no

Norwegian Radiation Protection Authority (Statens strålevern): www.nrpa.no

Sintef helse: www.sintef.no/helse

Norwegian Institute for Alcohol and Drug Research, SIRUS: www.sirus.no
Norwegian Bank (Norges Bank) www.norgesbank.no
Norwegian law on the web (Lovdata): www.lovdata.no
Regional Health Authority West (Helse-vest): www.helse-vest.no
Regional Health Authority Centre (Helse-midt): www.helse-midt.no
Regional Health Authority North (Helse-nord): www.helse-nord.no
Regional Health Authority East (Helse-øst): www.helse-ost.no
Regional Health Authority South (Helse-sør): www.helse-sor.no
WHO Commission on Macroeconomics and Health, 2001 <http://www.who.int/macrohealth>.

10.3 A selected list of laws

Abortion law (Lov om svangerskapsavbrudd) LOV-1975-06-13-50
The Social Security Act (Sosialtjenesteloven) LOV-1991-12-13-81
The Municipalities Health Services Act (Kommunehelsetjenesteloven) LOV-1982-11-19-66
The Specialized Health Services Act (Spesialisthelsetjenesteloven) LOV-1999-07-02-61
The Health Care Personnel Act (Helsepersonneloven) LOV-1999-07-02-64
The Patients' Rights Act (Pasientrettighetsloven) LOV-1999-07-02-63
The Mental Health Care Act (Psykisk helsevernloven) LOV-1999-07-02-62
The Communicable Diseases Act (Lov om vern mot smittsomme sykdommer) LOV-1994-08-05-55
The Supervision Act (Lov om statlig tilsyn med helsetjenesten) LOV-1984-03-30-15
The Act of Patient Compensation (Pasientskadeloven) LOV-2001-06-15-53
The Pharmacy Act (Aptekloven) LOV-2000-06-02-39
The Dental Health Care Act (Lov om tannhelsetjenesten) LOV-1983-06-03-54
The Health Enterprise Act (Helseforetaksloven) LOV-2001-06-15-93

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- to describe accurately the process, content and implementation of health care reform programmes;
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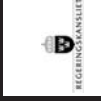
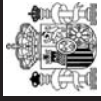
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Key

All HiTs are available in English.
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