

Introduction

Government and recent political history

Norway has been a constitutional monarchy since 1814 and in 1905 it became independent from Sweden. It is governed by three popularly-elected bodies: the national parliament, the county councils and the municipal councils. Politically it has been stable, and dominated by the Labour Party.

Population

The population is estimated to be 4.45 million (1999). The natural population growth rate reached 3.4 per 1000 in 1997, a figure well above the average EU levels. The main reasons for this are migration and the rise in average life expectancy. Future trends point to a growing and aging population. Fertility rates stood at 1.8 in 1999, the highest figure within the Scandinavian countries.

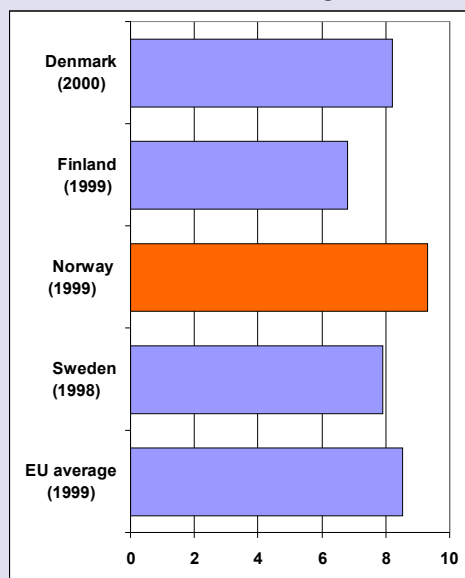
Average life expectancy

In 1998 it was 75.5 years for males and 81 years for women (1998), which are at average EU levels.

Leading causes of death

Coronary heart disease and cancer are the most prevalent causes of death, but from the 1970s to the 1990s, mortality from cardiovascular diseases decreased. Death rates from ischaemic heart disease, cancer among females and suicide for males are above the average EU levels. Infant mortality has decreased from 7 per 1000 live births in 1990 to 4.1 in 1997.

Fig. 1. Total health care expenditure as % of GDP, comparing Norway, selected countries and EU average



Source: WHO Regional Office for Europe health for all database.

Recent history of the health care system

From about the mid-19th century some municipalities hired physicians to care for the sick poor. The public hospital network started to develop around the turn of the century. The strong historical roots of local self-government is currently reflected in an ongoing process of devolution of central government to municipalities and counties, focusing as much as possible on the municipal level.

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Reform trends

During the 1990s a broad range of reforms was discussed and approved in Norway. Major pieces of legislation were passed in the following fields: the regulation of patients' rights, including patients' choice of hospital; the regulation of regional planning of health care services; the establishment of a prospective hospital financing system; and the approval of a reference price system for pharmaceuticals.

Health expenditure and GDP

Since 1992 expenditure as a percentage of the GDP has been increasing. It accounted for 8.9% in 1998, above the EU average. Health care expenditure in US \$PPP per capita was 2017 (1998), a figure above the average EU level. Public expenditure consists of nearly 82.2% of the total (1997).

Overview

The Norwegian health care system is tax-based and is founded on the principles of universal access to health care services, political decentralization to local governments and free choice of provider. During the last few decades, there has been significant progress regarding policy instruments to support such commitments, and many achievements have been made. However, there are areas for improvement needing attention, coupled with an aging population and increased demands on the health care system.

Organizational structure and management

The organizational structure of the health care system has three main levels, which relate to the country's three political tiers: the central state, 19 counties, and 435 municipalities. However,

to avoid duplication of services, there have also been attempts to have a meaningful regional level in the health care sector, consisting of 5 health regions which are administrative entities managed by counties.

All residents in Norway are insured under the National Insurance Scheme (NIS). Responsibility for the provision of services is decentralized, and the central level is ultimately responsible for regulating and supervising services.

National government level

There are three national bodies overseeing the health care system: the Ministry of Health and Social Affairs; the National Institute for Public Health; and the National Board of Health. The Ministry is responsible for framework legislation, capacity expansion, budgeting and planning, information management and policy design. The government also directs the National Institute for Public Health, as well as some research and prevention bodies. Finally, the Norwegian Board of Health is an independent professional body that, in collaboration with the county medical offices, is responsible for supervision and for promoting quality and legal safeguards.

The Ministry of Local Government and Local Authorities is responsible for distributing block grants to municipalities and countries.

Regional level

For cost-effective provision of high quality specialized health services, the country was divided into 5 health regions in 1974, and regional health committees were established in each region. Thus far, the impact of these committees has been limited. In the early 1990s, national authorities tried to revitalize them and again in 2000, as each region became required to submit strategic plans to the Ministry showing how they aim to fulfil national health policy goals.

County level

Norway's 19 county councils are responsible for the financing, planning and provision of

specialized care. This includes general and psychiatric hospitals, as well as other specialized medical services (e.g. laboratory, radiology), special care for alcoholics and drug addicts, and dental care for adults.

Municipality level:

The country's 435 municipalities, of varying size, are responsible for the provision and financing of primary health care and social services. Usually, each municipality has three separate administrative departments: for medical care; for nursing and home care; and for social welfare.

In 1986, municipalities were given the authority to prioritize services, on the assumption that autonomy in financing and service provision would better serve local needs.

Planning, regulation and management

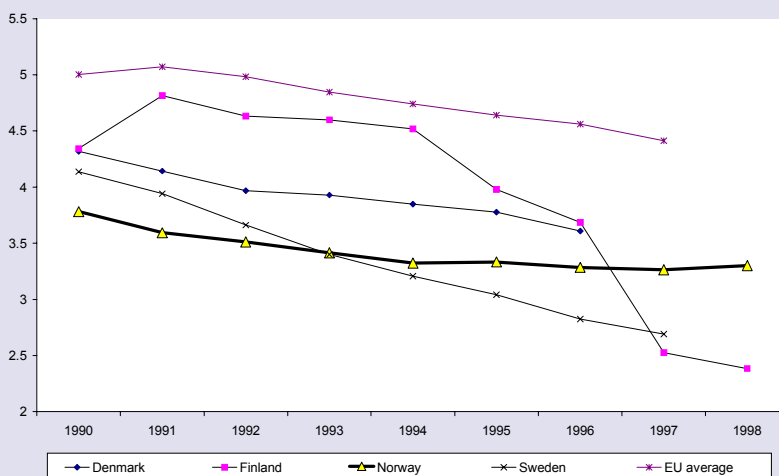
Public health care delivery in Norway is almost a fully integrated system. Most hospitals are owned by public authorities and are organized as public institutions.

Responsibility for providing services is decentralized, but there are large elements of centralized planning, as broad guidelines for priority setting are found in official documents, and regional health plans have to be authorized by the Ministry.

Health care finance and expenditure

The health care system covers the whole resident population of Norway. The most important feature is the predominance of tax-financed public provision together with limited out-of-pocket payments. Different actors take part in the intermediate financing flows: the national government, the counties and the municipalities (with the right of levying taxes, in addition to central state taxation), and the National Insurance Service.

Fig. 2. Hospital beds in acute hospitals per 1000 population, Norway, selected countries and EU average



Source: WHO Regional Office for Europe health for all database.

The proportion of public health financed by counties has been reduced to less than 30% in 1997 while the proportion of state-financed expenditure increased to more than 50% at the end of the 1990s. As there are significant cross-county flows of patients, there is a price system through which the county where the patient resides compensates the county where the patient is treated. Finally, the NIS finances about 15% of total public health care expenditure (mainly in sectors such as pharmaceuticals, fees of private contract-out doctors and transportation).

Health care benefits and rationing

The health care system guarantees universal access to a benefit package consisting of most preventive and curative services. Adult dental care and spectacles are generally excluded. Pharmaceuticals are divided into three categories. Non-prescription medicines are fully paid for by the individual, and prescriptions are either covered by the NIS (“blue prescription”) or paid

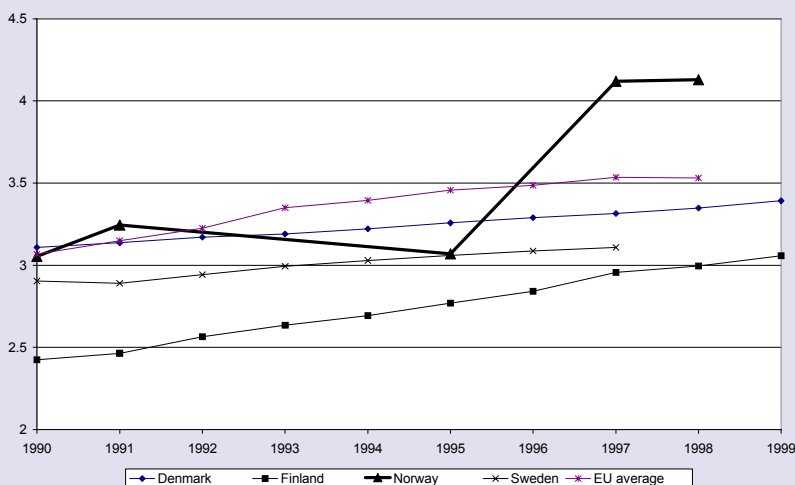
for in full by the patient (“white prescriptions”). There is a co-payment on blue prescriptions which is limited to 36% of the prescription fee.

Complementary sources of finance

The role of private insurance in Norway is very limited. Therefore, out-of-pocket payments constitute the main complementary source of finance. In the case of secondary care, patients are charged 19 euros for each visit to a hospital outpatient clinic. There are also co-payments for laboratory tests, X-rays and some pharmaceuticals at the outpatient clinic. The patient also pays a share of the cost of treatment by a general practitioner or a specialist outside the hospital; for treatment by a psychologist; for prescriptions of important drugs and for transportation expenses in connection with examination or treatment. Co-payments amount to about 10% of public health care expenses.

An annual ceiling for cost-sharing was introduced in the early 1980s. In 1996 it was 165 euros per year on all co-payments including

Fig. 3. Physicians per 100 population, Norway, selected countries and EU average



Source: WHO Regional Office for Europe health for all database.

prescriptions, outpatient care or primary care. There are also certain exemptions from cost sharing for special diseases and specific groups of people.

Attempts to provide complementary voluntary health insurance have not been successful although there is an increasing tendency for private health care centres to be set up in the urban centres of Norway.

Health care expenditure

In 1998, the health care expenditure as a percentage of GDP stood at 8.9%, and in US \$PPP per capita was 2017, well above the average EU level. The public proportion of total expenditures on health has been rather stable during the 1990s and in 1997 it accounted for 82.2% of the total.

From 1997 to 1998 public health expenditures grew by 8.5%, mainly due to higher expenditure on pharmaceuticals, increased spending by the municipalities for care of the elderly and disabled and by the counties for specialized psychiatric care.

Among different categories of expenditure, public health prevention, rehabilitation, pharmaceuticals and elderly and disabled care experienced over average increases in the 1990–1998 period.

Health care delivery system

Primary care and public health services

Each municipality is responsible for providing primary health care services for its population, and must guarantee integrated services for disease prevention and health promotion, diagnosis and treatment of illness, rehabilitation and long-term care. The municipal board approves a health plan according to local needs and demands. Local politicians can determine the amount of funds to

spend on health, but the Local Authority Health Care Act defines a number of services which are mandatory at local level. There are regional officers in every county who are responsible for overall supervision of these services, and central government has seven specialized public health institutions, responsible for giving expert advice. Other national public health programmes exist, such as cancer screening programmes (e.g. for breast and cervical cancer), implemented through disease-specific bodies.

General practitioners (GPs) are a central part of the primary care system, and their most common organizational form is in groups of between two to six. They also have auxiliary personnel, although the amount of help depends on the size of the practice allowance from the municipality. Although it is not required, most GPs specialize in general/family medicine. The majority are either municipal employees (21% in 1998) or private contracted-out by the municipality (71% in 1998).

Choice of GP is in principle unrestricted, although often limited by geographic circumstances. The patient can be treated by a physiotherapist or a chiropractor directly, although these providers only receive reimbursement when referred. In addition, in order for specialists to be reimbursed for a consultation, patients need a referral from a GP.

Demands on GPs have increased in recent years, due to reductions in hospital capacity and length of stay, as well as increased focus of care on the patient. Thus, high priority has concentrated on improving GP services. With this aim, in 1997, a list system was introduced countrywide, consisting of an official patients' registration list, and income based on a combination of capitation and fee-for-service.

Secondary and tertiary care

Since 1969, counties have assumed responsibility for the financing, planning and provision of specialized health care. This includes general and

psychiatric hospitals, as well as other specialized medical services (e.g. laboratory), and dental care for adults. Counties enjoy considerable autonomy regarding the structure of hospital care.

The country is divided into five health regions, each with its own regional tertiary hospital. Four of these teaching hospitals are owned by counties and the fifth is state-owned. A few hospitals are owned by voluntary organizations, although they are treated as public hospitals. There is also a small private hospital sector, consisting of five very small private hospitals which emerged as a result of waiting lists for specific areas of care in public hospitals. There are tight restrictions on private hospitals in Norway.

While most services from medical and radiology laboratories are delivered by the hospitals, there are also 25 private laboratories and institutes that receive funds from the NIS.

From 1970 to 1990, the number of beds in somatic hospitals decreased by 35%, and in psychiatric hospitals, by 66%, as a result of emphasis on outpatient care and day treatment. Since 1990, hospital capacity has decreased more moderately. Average length of stay has steadily decreased. The average occupancy rate in hospitals is higher than in many European countries, while inpatient utilization rates are comparatively low. The number of somatic hospital beds per 1000 population is 3.1 (1998); if nursing homes and psychiatric beds are included, the number of beds per 1000 is 13.5.

The most urgent problem facing the health care system in the past decade has been absorbing patient inflows in hospitals. Different measures have been implemented to address this problem and although progress has been made, improvements are still needed and many patients are still waiting for hospital treatment.

Social care

Social care includes social welfare services, care for the elderly, the disabled and psychiatric

patients, and care for alcoholics and drug addicts. In general, the municipalities provide most of these services, and the personnel working in the sector are directly employed by the municipality. During the 1990s, municipalities gained increasing responsibility for providing social services. The availability and quality of social services vary considerably.

The basic principle of care for the elderly and disabled is that services and individualized support should be arranged in people's home communities. Most of the municipalities (80%) offer services 24 hours a day. Approximately 155 000 people used home care services in 1999, and there are over 43 000 beds in institutions for the elderly. The users pay an out-of-pocket fee for some of these services, and the size of the fee varies among the municipalities. There is a national debate regarding whether there should be guidelines as to the size of the fees, but the aim is to have fees low enough so that services are available for everyone.

Because of the aging population, the overall need for nursing and care services is expected to increase, and the country faces future challenges in this area.

Human resources and training

Health personnel are licensed by the chief county medical officer in Oslo, and unlicensed personnel cannot practice. One third of Norwegian physicians work in primary care and 95% of doctors are members of the Medical Association, entitling them to specialist training and continuing medical education. In the last few decades, professional training and the status of GPs have improved.

According to the WHO health for all database, Norway has 4.1 physicians/1000 (1998), the highest rate in the Nordic countries. However, the official national figures point to a different number, 2.5 physicians/1000. The data on nurses also vary by source, although they generally highlight a shortage of nurses, especially nurses with specialized skills. While the number of physicians and nurses per population is relatively

high, there are shortages in some geographic areas, mainly due to the scattered population. The regional distribution of GPs is not satisfactory, as it is difficult to recruit physicians to certain geographical areas. The number of dentists is not satisfactory either, especially in rural areas.

It is expected that the demand for physicians will increase. Efforts are being made to address problems in human resources in the health sector, to improve statistics concerning health personnel, and to deploy health personnel better and more effectively.

Pharmaceuticals

The pharmaceutical sector is one of the most regulated in Norway. The Norwegian Ministry of Health and Social Affairs has overall supervisory responsibility for pharmaceuticals, the Ministry sets the retail margins, and the Norwegian Medicines Control Authority registers and allows new types of drugs to enter the market. This Authority also sets the prices of pharmaceuticals. The Norwegian Board of Health, which distributes licences for drug production and trade, has overall supervision of drugs from the manufacturer to the end users of the pharmaceuticals.

The Board is also responsible for the location of pharmacies, and Norway has the lowest availability of pharmacies in Europe. Drug stores also exist in Norway, similar to pharmacies but without the presence of pharmacists.

Drug expenditures increased from 1990 to 1997. In 1997, about 54% were reimbursed by the National Insurance Scheme, 31% consisted of patient fees and the remaining proportion was from hospital sales.

Total reimbursement of drugs has increased each year, due to the inclusion of newer, more expensive drugs and to greater use of outpatient care. To reduce costs, a reference price system, using the cheapest brand available on the market within each group of identical drugs, was introduced in 1993. In 1998, this system was extended to include drugs subject to patent

protection but which may be imported under licence at a lower price.

There is strong pressure from the pharmaceutical industry to have new products registered and covered by the NIS. Increasing pressure from patients is also expected in the future.

Health technology assessment

The Norwegian Centre for Health Technology Assessment was established in late 1997, and it is organized within an independent non-profit research organization. Its main tasks are to assess new and established technologies and ensure their effectiveness and efficiency. The Research Council of Norway arranges conferences of consensus to promote good medical practice and make the right priorities within the health care system.

Financial resource allocation

The state level allocates funds to local governments on a weighted capitation basis. Local health services are financed through a combination of government revenues (block grants and earmarked grants); retrospective reimbursement by the NIS; and out-of-pocket payments. Even though the state does not, in principle, directly interfere with local resource allocation, in practise, central regulation and financing policies reduce local autonomy.

Payment of hospitals

The present financing system replaces a system of global budgets introduced in 1980, which had encouraged some counties and hospitals to lower activity so as to comply with budgetary restrictions. In 1997, the pressure to reduce waiting lists led to the introduction of the current activity-based financing system. The main purpose was to improve efficiency and to raise

hospital productivity. Although counties were not forced to incorporate the new system, in 1999 only one county upheld global budgeting.

Regarding hospital outpatient activity, traditionally it has been financed partly by a fee-for-service system and partly via global budgets. Since 1999, day care surgery, as well as hospital activity in general, has been financed based on diagnosis related groups (DRGs).

Payment of physicians

Outpatient primary and specialized services are delivered by both public salaried physicians and private practitioners. The latter are contracted out of the public health care system, and paid a basic grant combined with fee-for-service payment from the NIS. GPs with contracts are not allowed to charge fees other than those determined by the National Assembly and out-of-pocket payments are limited. Public hospital services, in contrast, are fully provided by salaried public (or quasi-public) employees.

Since 1998, NIS funding has been curtailed for private professionals who establish a new practice without a contract with the municipality or county. This measure aims at freeing up human medical resources for the remote areas.

Health care reforms

During the 1990s, increased efficiency and accessibility dominated the political agenda.

Additional funding was targeted to reduce waiting lists and a reference price system was established in 1993 and extended in 1998. During the late 1990s, several reforms were approved such as the structural changes introduced in the hospital financing system and the reform of the conditions for reimbursement to private physicians. In addition, several legislative pieces were approved during the period 1998–1999. Among these, there are some that deserve special mention. First, the introduction of regional health planning, commissioned to regional health committees made up of local government representatives. Second, the Act on specialized care emphasizes that mental care should be integrated within health services and turns provision of psychiatric nursing homes and private care to the municipalities. Thirdly, major elements in the legislation on patients' rights are the right to choose among public hospitals; the guarantee of access to a specialist within thirty working days after the referral from the general practitioner is received; the right to a second opinion; and the right to an individualized care package for patients who need long-lasting, integrated care. Finally, a reform to be approved by spring 2000 introduced a list system in primary care that would also allow citizens to choose another physician as their general practitioner and to obtain a second opinion by another GP.

Future proposals focus on the liberalization of the drug retail network to allow for greater competition; reinforced incentives for doctors to prescribe the cheapest drugs; greater hospital

Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2000 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Denmark	3.3 ^a	19.2 ^a	5.5	79.9 ^a
Finland	2.4	19.3 ^d	4.3	74.0 ^e
Norway	3.1	14.5 ^d	6.0	85.2
Sweden	2.5	15.9 ^d	5.5 ^a	77.5 ^d
EU average	4.2 ^a	17.1 ^a	8.2 ^b	77.0 ^b

Source: WHO Regional Office for Europe health for all database.
Note: ^a 1999, ^b 1998, ^c 1997, ^d 1996, ^e 1995, ^f 1994, ^g 1993.

autonomy in management and organization. However, Norway has not yet taken steps towards a separation between the providing and purchaser functions.

Conclusion

A great deal of progress has been made during the 1990s, but new challenges will need to be faced in the future. One of these challenges is to

combine a decentralized system with a regulatory environment that ensures equal access. The most important measures adopted are targeted at reducing and prioritizing waiting-list patients, reinforcing regional planning, and overseeing a proposed official list patient system for GPs. In addition, areas of focus for the future include considering new forms of hospital management and ownership, addressing labour supply constraints, and developing a clear division of responsibility between the state and the counties regarding hospitals.

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The Observatory is a unique undertaking that brings together the WHO Regional Office for Europe, the Governments of Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.