

Introduction

Government and recent political history

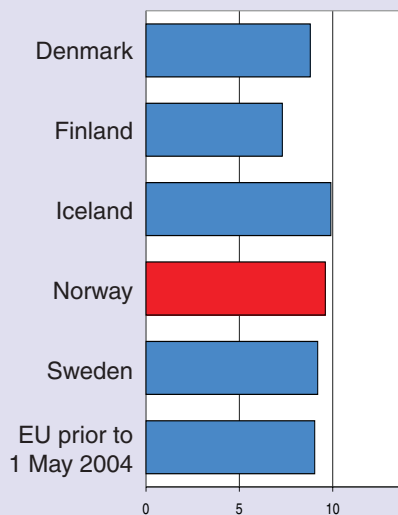
Norway has been a constitutional monarchy since 1814, and the country became formally independent in 1905. The King is officially the highest executive authority, although in practice the government cabinet is at the head of the executive power. Norway is governed by a three-tiered parliamentary system, with each tier run by a popularly elected body: the national Parliament (Storting), the county councils and the municipalities. There were 19 counties and 431 municipalities in 2006.

Central government, specifically the Ministry of Health and Care, is responsible for secondary health care. The municipalities are responsible for health promotion, primary health care, care of the elderly and care of the physically and mentally disabled. The counties are responsible for dental health care.

Population

The population of Norway passed 4.6 million in 2005. On average there are 15 persons per km². The natural population growth rate, which steadily decreased from the start of the 1970s to less than 2 per 1000 in the mid-1980s, started to increase again, reaching an average of 3.4 per 1000 in the period 1996–2000, a figure well above average EU levels. At the beginning of 2004 the immigrant population in Norway was 349 000 and accounted for 7.6% of the total population.

Fig. 1 Total health care expenditure as a percentage of GDP, comparing Norway with selected countries and the EU average, 2002, WHO estimates



Source: European Health for All database, January 2006.

Note: EU: European Union.

Average life expectancy

There was a considerable improvement in life expectancy throughout the 20th century. In 2004 life expectancy at birth was 77.5 years for males and 82.33 years for females. This is a significant increase over the period 1946–1950, when the

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average figures were 69.25 years for males and 72.65 years for females.

Leading causes of death

Mortality due to diseases of the circulatory system has been significantly reduced during the last 30 years, and this is one of the major factors that have contributed to the rise in life expectancy. Diseases of the circulatory system are, however, still the leading cause of mortality, accounting for almost a third of deaths in 2003. Health promotion interventions, including those to prevent accidents, brought positive results in Norway. Mortality from external causes has been reduced by 20% during the last three decades. There has been some increase in mortality as a result of mental diseases and cancer during the same period.

Recent history of the health care system

The years following the Second World War can be described as a period of continual reform in the relationship between state and local government. The goal has been to find an acceptable balance of power between these two levels of government. Power continues to be devolved from central to local government, with the aim of focusing as much as possible on the municipal level and enabling counties/regions and municipalities to take over service provision. The administrative level, which is responsible for implementing and providing various services, has also been given responsibility for financing. In order to cover expenditures, the municipalities and counties draw on local taxes (mostly income and property taxes from individual taxpayers) in addition to block grants and earmarked grants from the state for high-priority reforms.

With regard to specialized care, there was no general Act regulating the hospital sector until the Hospital Act was passed in 1969. Since its adoption, each of Norway's 19 counties assumed responsibility for the financing, planning and provision of specialized health care. In 1974, the White Paper on Hospital Development in

a Regional Public Health Service set out an overall fundamental strategy of health services at regional level. In 2002 the responsibility for specialized health care was transferred to central government. The country was divided into five regional health authorities with responsibility for organizing specialized health care within a health enterprise structure.

Reform trends

Taking an aggregate view of health care reform over several decades, the general focus of the 1970s was on equity questions and the build-up of health services; the 1980s on cost containment and decentralization; the 1990s on efficiency and leadership; and the beginning of the new millennium on structural changes in the delivery and organization of health care.

Health expenditure and GDP

In 2005, Norwegian health care expenditure was around 10% of GDP (Figure 1). Health care expenditure as a share of GDP has been increasing steadily during the last twenty years from 6.9% in 1980. In comparison with other Nordic countries in 2002, health expenditure as a percentage of GDP in Norway was lower than in Iceland (10.0) and higher than in Denmark (8.8), Finland (7.2) and Sweden (9.2).

Overview

Organizational structure of the health care system

The health care system in Norway is organized on three levels: the central state, the five regional authorities and the municipalities. While the role of the state is to provide 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 and the 431 municipalities. At the national level, the parliament 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.

The country's 431 municipalities, whose sizes vary considerably, are responsible for the provision and funding of primary health care and social services. All citizens have the right to access to health care services in their community. Norway's five regional health authorities are responsible for the financing, planning and provision of specialized care. This includes somatic care and mental health/substance abusers care, as well as other specialized medical services, such as laboratory, radiology and paramedical services. There are at present 31 health enterprises under the five regional health enterprises.

Planning, regulation and management

At the national level, the political decision-making body is the parliament. The executive body is the Ministry of Health and Care. The responsibility of the national bodies is to determine policy, prepare legislation, undertake national budgeting and planning, organize informal channels, and approve institutions and capacity expansion. The municipalities provide primary health care, including nursing care for the disabled and the elderly, while responsibility for specialized health care lies with the regional health authorities that are owned by the central government. Dental care is still part of the county's responsibility.

The health care system is mostly publicly owned, although there are some contracts with private agencies, mainly between municipalities and GPs, and between the regional health authorities and specialist physicians. The Ministry of Health and Care provides instructions to the regional health authorities through a "letter of instruction", which is prepared individually for each of the five authorities and can be seen as a "government supplement". The governance of the municipalities relating to primary health care is in practice an interplay between a number of different ministries, such as the Ministry of Health and Care, the Ministry of Labour and

Social Inclusion, and the Ministry of Local Government and Regional Development.

Decentralization

Decentralization has been one of the characteristics of the Norwegian health care system but the hospital reform of 2002 changed the system from a decentralized to semi-centralized one. The regional health authorities, represented by the state, are responsible for specialized health care, while the municipalities are responsible for primary health care.

In their organizational structure, the regional health authorities and the health enterprises may be seen as state-owned companies. Principal health policy objectives and frameworks are determined by central government and form the basis for the management of the enterprises, while day-to-day management is the responsibility of the general manager and the executive board.

The municipalities are run by locally elected politicians together with their administrative staff. Health care is one of many areas for which they are responsible. The municipalities are free to set up their own organizational structure.

Health care financing and expenditure

Main sources of financing

Sources of revenue for health care in Norway include taxation, national social insurance systems and private expenditure. The Norwegian health care system is primarily funded through taxes which are raised at municipality, county and central levels. Following parliament's approval, the central government sets the municipalities' and counties' maximum tax rates. There is no specific health tax in Norway, and the regional health authorities cannot themselves draw taxes. During the last 20 years, the proportion of public expenditure on health has been steady at around 85%.

Complementary sources of financing

All residents of Norway or people working in the country are insured under the National Insurance Scheme (NIS), which is run by central government. The NIS is financed by contributions from employer, employees, self-employed people and state funding. People insured under the NIS are entitled to retirement, survivors' and disability pensions, basic benefits and attendance 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. Health care expenditure by NIS in 2002 was almost Nkr 20 000 million, or approximately 10% of total NIS expenditure. Voluntary health insurance does not play any significant role in Norway.

Out-of-pocket payments

With regard to health care services, inpatient care in general hospitals does not involve out-of-pocket payments, but these are payable for consultations with private specialists, ambulatory care, GPs, X-rays, laboratory tests and drugs. Most of these out-of-pocket expenditures are included in the cost ceiling scheme that was introduced in the early 1980s. The ceiling is set each year: in 2006 it was Nkr 1615. When the cost ceiling has been reached in any calendar year, most of additional out-of-pocket expenses is reimbursed by the NIS, and remaining treatment in that calendar year is therefore free of charge. In 2005 around 1 million Norwegians reached this ceiling.

According to OECD, the share of out-of-pocket expenditure in the Norwegian health care system has been stable during the last two decades at about 15%.

Health care expenditure

According to the OECD database, health care expenditure expressed in US\$ PPP per capita

was US\$ 3616 in Norway in 2002, which was higher than for neighbouring countries, Sweden (US\$ 2594), Denmark (US\$ 2655), Finland (US\$ 2013) and Iceland (US\$ 2948). Recent figures for 2006 indicate that Norway's health expenditure measured in US\$ PPP is second to the United States.

Health care delivery system

Primary health care

The municipalities are responsible for providing primary health care and ensuring the wellbeing of the population, as well as good social and environmental conditions. Furthermore, they are responsible for providing information on health and encouraging lifestyle activities for the community that promote public health and individual health and wellbeing. The decision regarding the amount of local funds that can be spent on the health sector is left to the discretion of local politicians.

Primary health care and general practice are well established in Norway. General physicians form the central part of the primary health care system, and the most common structures comprise teams of two to six physicians. In 2001, each municipality was given the responsibility to provide a physician for every citizen; a regular general practitioner scheme was established. The municipalities meet this obligation through contracts with general physicians. According to the Ministry of Health and Care, the scheme is functioning well, with 98% of the population having a regular general physician.

The provision of emergency care (that includes the general physicians) is also an important task for the municipalities.

Public health services

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; these comprise: Norwegian Directorate for Health and Social Affairs, Board of Health, National Institute for Public Health, Norwegian Medicines Agency and Norwegian Radiation Protection Authority.

The county governors are responsible for the overall supervision of health services in their counties. The aim is to decentralize the provision of public health services as much as possible in order to guarantee the shortest possible distance between provider and consumer.

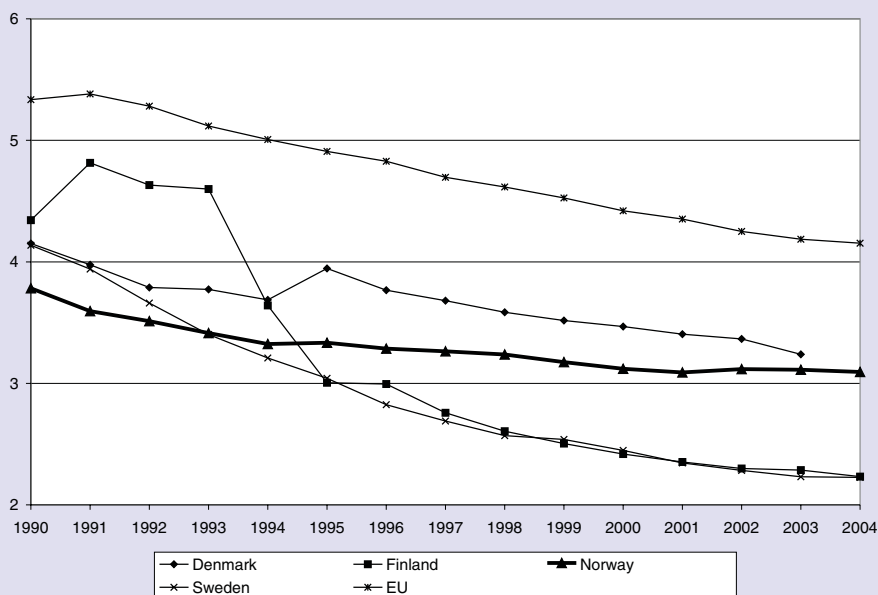
The White Paper Report No. 16 (2002–2003), *Prescriptions for a healthier Norway: a broad policy for public health*, outlines the national public health strategies for the next 10 years. It sets the agenda for a healthier Norway, achieved

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.

Secondary and tertiary care

In 2002, the Norwegian Hospital Reform was implemented, and the responsibility for secondary care was transferred from the counties to the five regional health authorities, forming a health enterprises structure. The purpose of the health enterprises is to deliver specialized health care services of high quality and equity to anyone in need, regardless of age, gender, location, income or ethnic origin, as well as facilitating research and innovation. Each regional health authority has a statutory duty to provide equal access to hospital services for those who live in its catchment area. Each hospital is now a discrete legal entity, with a managerial board responsible for all its activities. The regional health authorities may contract out

Fig. 2 Beds in acute hospitals per 1000 population in Norway and selected countries, 1990–2004



Source: European Health for All database, January 2006.

some services to private hospitals or agencies. The regional health authorities are financed via global budgets, activity-based financing (fee-for-services and DRG-reimbursement) and patients' out-of-pockets payments. Each region has a different degree of tertiary level services, where most of the tertiary level services are conducted in hospitals situated in urban areas.

Long-term care

The organization of long-term care is the responsibility of the municipalities in Norway. There are types of long-term care services: nursing homes, sheltered (adaptable) houses, and home-based services. Since the mid-1990s, there has been a significant increase in the number of people using nursing and care services provided by the municipalities.

Human resources and training

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. Coverage has been improving in the last 4–5 years, and nursing coverage is the second highest in Europe after Finland.

Four public universities in Norway run medical education programmes, based on grades from a tertiary education diploma. After the 6-year basic medical education, there is an internship period

of 18 months. This period has traditionally been an important regional policy tool, and internship positions have been concentrated in rural areas. There are 30 basic specialties, eight medicine and five surgery branch specialties. The average minimum time required to obtain a specialty is five years. There are 27 educational institutions in Norway, offering basic nursing education, 22 of these are university colleges, and the remainder are located in health care institutions. There is standard minimum entry requirement for nursing education (this normally means that the student must have completed three years of tertiary education). With the introduction of the hospital reform in 2002, there has been an increased focus on leadership and management training within the public hospital sector. The Norwegian Board of Health is the government agency that decides on disciplinary measures in the event of medical malpractice.

Pharmaceuticals

The Norwegian Medicines Agency is responsible for preparing recommendations concerning the acceptance of drugs into the reimbursement scheme, based on established criteria. There is a price and profit scheme in operation for prescription drugs. Prices are regulated according to the European Economic Area (EEA) rules, and the pharmacies' margins are set by parliament. Price regulation for generics is subject to the same regulations as their original counterparts.

Table 1 Inpatient utilization and performance in acute hospitals in the WHO European Region, 2004 or latest available year

	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Denmark	3.2 ^a	17.8 ^c	3.6 ^a	84.0 ^c
Finland	2.2	19.9	4.2	74.0 ^f
Norway	3.1	17.3	5.2	86.4
Sweden	2.2	15.1	6.1	77.5 ^b
EU15 average	4.0 ^a	18.0 ^c	6.9 ^a	77.0 ^c

Source: European Health for All database, January 2006.

Notes: ^a 2003; ^b 2002; ^c 2001; ^d 2000; ^e 1999; ^f 1998; ^g 1997; ^h 1996; ⁱ 1995; EU: European Union; EU15: Member States before 1 May 2004.

Non-prescription (over-the-counter) drugs are not subject to price and profit regulation. Direct-to-consumer advertising on prescription drugs is not allowed.

Financial resource allocation

Payment of health care facilities

The main source of funding to the municipalities consists of block grants from the state and local taxes. The state has a distribution formula, which determines the amounts 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 such services. The most important weighting is age-related, as the demand for health care and care for the elderly depends to a large extent on demographic characteristics. There are three sources of funding for emergency services: block grants from the municipalities, out-of-pocket payments and reimbursements from the NIS. Nursing homes and sheltered houses are funded by block grants from the municipalities and out-of-pocket payments.

The regional health authorities are funded by state grants with a block grant element and an activity-based element. Somatic inpatient care (and some day surgery procedures from 1999), have been financed through the Activity Based Financing (ABF) scheme since 1997 (based on the DRG-system). There is also tariff reimbursements from the NIS based on fee-for-service for ambulatory care, X-rays and laboratory services. The regional health authorities are free to set up their own funding system for their health enterprises and other institutions.

Payment of health care professionals

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

self-employed personnel such as physician specialists with RHA agreements paid by fee-for-service from the NIS, out-of-pocket payments and block grants from the RHA; and regular GPs paid by fee-for-service from the NIS, out-of-pocket payments and capitation from the municipalities. The main salary negotiations for public health care professionals are normally set between the state/municipalities as employers and the health care personnel member organizations.

Health care reforms

The purpose of the Municipalities Health Care Act of 1984 was to coordinate health and social services at the local level, to strengthen these services in relation to institutional care, to strengthen preventive care, and to pave the way for better allocation of health care personnel. The Act provides the municipalities with a tool by means of which comprehensive health services are provided in a coordinated way. In 1988 the Municipalities Health Care Act was further expanded and responsibility for nursing homes was transferred from the counties to the municipalities.

In 1997, Norway introduced Activity Based Funding (ABF), based on the DRG (diagnosis related group) system. The introduction of ABF was followed by a substantial increase in the number of cases treated and a reduction in waiting times. The system includes approximately 500 different treatments for hospitalization, day surgery and some day medical procedures. This system does not include outpatient treatments where there are special reimbursement rates from NIS, patients who pay for themselves (for instance, foreign patients) and mental hospitals. DRG weightings and reimbursement are equal in all hospitals, irrespective of cost structure, case mix or type of hospital. A current national set of cost weightings is estimated on the basis of costs in selected hospitals.

The General Practitioners Scheme implemented in 2001 is based on a system through which patients register with a physician of their choice. Basic principles include the individual's right to choose whether or not to participate in the system, their right to choose another physician as their GP (twice in a year) and the right to a second opinion by another general physician. The aim of the reform was to improve the quality of the local medical service, to ensure continuity of care and encourage a more personal patient–physician relationship. This reform also embodies 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 base.

The hospital reform in 2002 aimed to increase efficiency and consisted of three main strategies: the ownership of the hospitals was transferred 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 of the hospital reform show some positive outcomes, such as decreased waiting lists and improved management skills.

In 2001 a new law was passed allowing greater freedom to establish pharmacies, which led to vertical integration of pharmacy chains owned by wholesale companies, and allowed pharmacies to substitute a physician's prescription with another (e.g. generic) brand. This reform resulted in an increased market share for generics. More recent efforts to regulate the pharmaceutical market include the index price system introduced in 2003 allowing the retailer to gain extra margins if they choose a cheaper drug rather than an expensive one. This reform was replaced in 2005 by a step-price system that cut the reimbursement of off-patented drugs.

The Tobacco Law of 2004 banned smoking from 1 June 2004 wherever food and/or drinks are served and where these items are consumed. The main purpose of the Act was to protect employees and other guests against passive smoking.

Municipalities maintain the supervision of the legislation on smoke-free restaurants.

Conclusions

Norway has been successful in implementing numerous reforms in primary and secondary health care, financing, mental and public health sectors, pharmaceuticals and other sectors.

Several preconditions for the country's successful health policy can be highlighted. Norway's decision-making process has been consensus-oriented. Most decisions have been made through negotiations with interested parties, with the Norwegian Medical Association as one of the key players. The policy process can be characterized as a 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 'steering, not rowing' principle, whereby politicians are concerned more with strategy and less with implementation). In addition, political commitment to place the health system at the top of the agenda has been a driving force in Norway.

There are some remaining challenges that need to be addressed in future.

- Integration of health and social care services. Two Royal Commissions on legislation of social and health sectors and on organization of different levels in health care sectors were created in 2003. Their objective is to identify means for improving coordination at different levels and sectors. This applies especially with regard to elderly and disabled people with complex diagnoses and chronic conditions, who would benefit from stronger integration of health and social services.
- Further development of patient classification systems based on hospital stay or activity groups. This would facilitate the gathering of comparative information from the hospitals.

- Inequalities in health. Reducing these inequalities is a social priority; however, the effects of policies to reduce them are often not well documented. How these inequalities in health will be addressed in the future is a profound challenge for the Norwegian health care system.
- Finding the optimal structure of the municipalities and regional self-government.
- Finally, interventions to reduce alcohol and drug abuse especially among young Norwegians, 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 a decentralized health system contributes to the involvement of individual users in the policy-making process. The implementation of recent, and earlier, reforms in the health sector shows significant political commitment. The development of the health system in Norway illustrates the possibilities for the successful achievement of political and social goals.

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The Health Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Systems and Policies.

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