Norway

Health system summary 2024

European Observatory on Health Systems and Policies
a partnership hosted by WHO

Authors

Ingrid S Saunes
Béatrice Durvy
Yulia Litvinova

Anna Maresso (Series Editor)

Contents

This Health System Summary is based on the *Norway: Health System Review* (HiT) published in 2020 but is significantly updated, including data, policy developments and relevant reforms as highlighted by the Health Systems and Policies Monitor (HSPM) (www.hspm.org). For this edition of the Health System Summary, key data have been updated to those available in September 2024 unless otherwise stated. Health System Summaries use a concise format to communicate central features of country health systems and analyse available evidence on the organization, financing and delivery of health care. They also provide insights into key reforms and the varied challenges testing the performance of the health system.

Main sources:

Saunes IS, Karanikolos M, Sagan A. Norway: Health System Review. *Health Systems in Transition*, 2020; 22(1): i–163.

Health Systems and Policy Monitor (HSPM) – Norway (2024). European Observatory on Health Systems and Policies, https://eurohealthobservatory.who.int/monitors/health-systems-monitor.

Please cite this publication as: Saunes IS, Durvy B, Litvinova Y. *Norway: Health System Summary*, 2024. Copenhagen: European Observatory on Health Systems and Policies, WHO Regional Office for Europe; 2024. Licence: CC BY-NC-SA 3.0 IGO.

ISSN 2958-9193 (online)

ISBN 9789289014380 (PDF)

How is the health system organized?

In Norway, regions are responsible for delivering specialized care, while municipalities manage primary care. Healthcare Communities coordinate care across these levels.

Organization

In Norway, the healthcare system is semi-decentralized. The central government, through the Ministry of Health and Care Services, oversees specialist care, which is delivered by four Regional Health Authorities (RHAs) that own a total of 20 hospital trusts. Municipalities are responsible for organizing and providing primary care, rehabilitation, nursing and after-hours emergency services.

The network of Healthcare Communities (*helsefellesskap*) facilitates joint planning and coordination of care between the municipalities and the hospital trusts. This network also includes general practitioners (GPs) and patient representatives. The Healthcare Communities ensure a patient-centered common understanding of targets and expectations set by the central government (see Box 1).

The Ministry of Health and Care Services and its subordinate agencies are responsible for planning, regulating, and supervising the health system. In December 2023, the Ministry of Health and Care Services reorganized these agencies, streamlining their roles and responsibilities. The Directorate of Health's authority was reinforced and its role now includes responsibilities for digitalizing health and care services, and the Institute of Public Health (NIPH) was enhanced as a knowledge agency.

Box 1 Capacity for policy development and implementation

In March 2024, the Norwegian Government adopted the National Health and Cooperation Plan 2024–2027, titled Our Joint Health Service, which replaces the National Health and Hospital Plan 2020–2023. In the new document, the government sets objectives to create a health-promoting society, prevent disease and ensure a decentralized health and care service that provides high-quality, safe and equitably accessible services throughout the country. The plan aims to provide municipalities and counties with the tools to meet future challenges, including workforce development, improved care coordination and integration, and shorter waiting times (Government of Norway, 2024).

Counties and municipalities have high legitimacy and capacity to implement health policies and plans, and healthcare and health-related services are among the most important tasks of municipalities, consuming more than a third of their total resources. Nevertheless, small rural municipalities face challenges as they often have a lower level of compliance than the larger municipalities, mainly due to a lack of capacity and expertise (Ministry of Local Government and Regional Development, 2023).

Planning

Every 4 years, the Ministry of Health and Care Services updates the National Health Plan, which outlines the main targets for the health system's development. The plan presents the current status of the healthcare system, highlights key challenges, and suggests policy goals and measures to address them (see Box 1). Policies responding to these goals are then implemented through more detailed and topic-focused national strategies and plans. Recent examples include the Health Industry Roadmap, the Strategy for Personalized Medicine, and an upcoming comprehensive strategy for non-communicable diseases (NCDs) towards 2030.

Providers

Most GPs in Norway are self-employed and work under contract with the municipalities. GPs play a gatekeeper role to specialist care. Specialist outpatient care is provided either in hospital outpatient departments (known as polyclinics), or by self-employed specialists working under contract with the RHAs. Hospital trusts, which are owned by the RHAs, are the main providers of inpatient specialist care. Since January 2023, patients' choice of hospital has been limited to public providers and private providers with a public tender agreement. The private hospital care sector is relatively small but well-regulated.

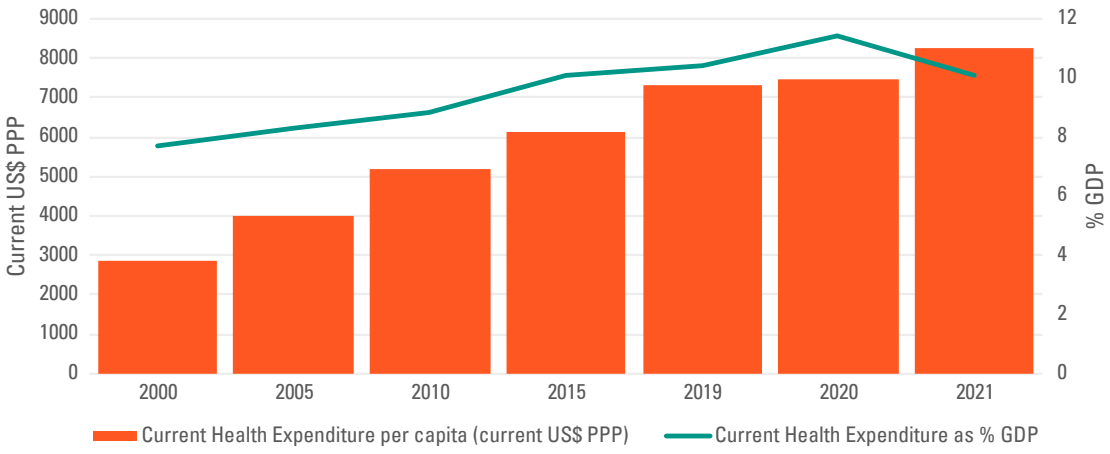
How much is spent on health services?

Norway's health expenditure remains among the highest in Europe and is mostly financed through public funds.

Funding mechanisms

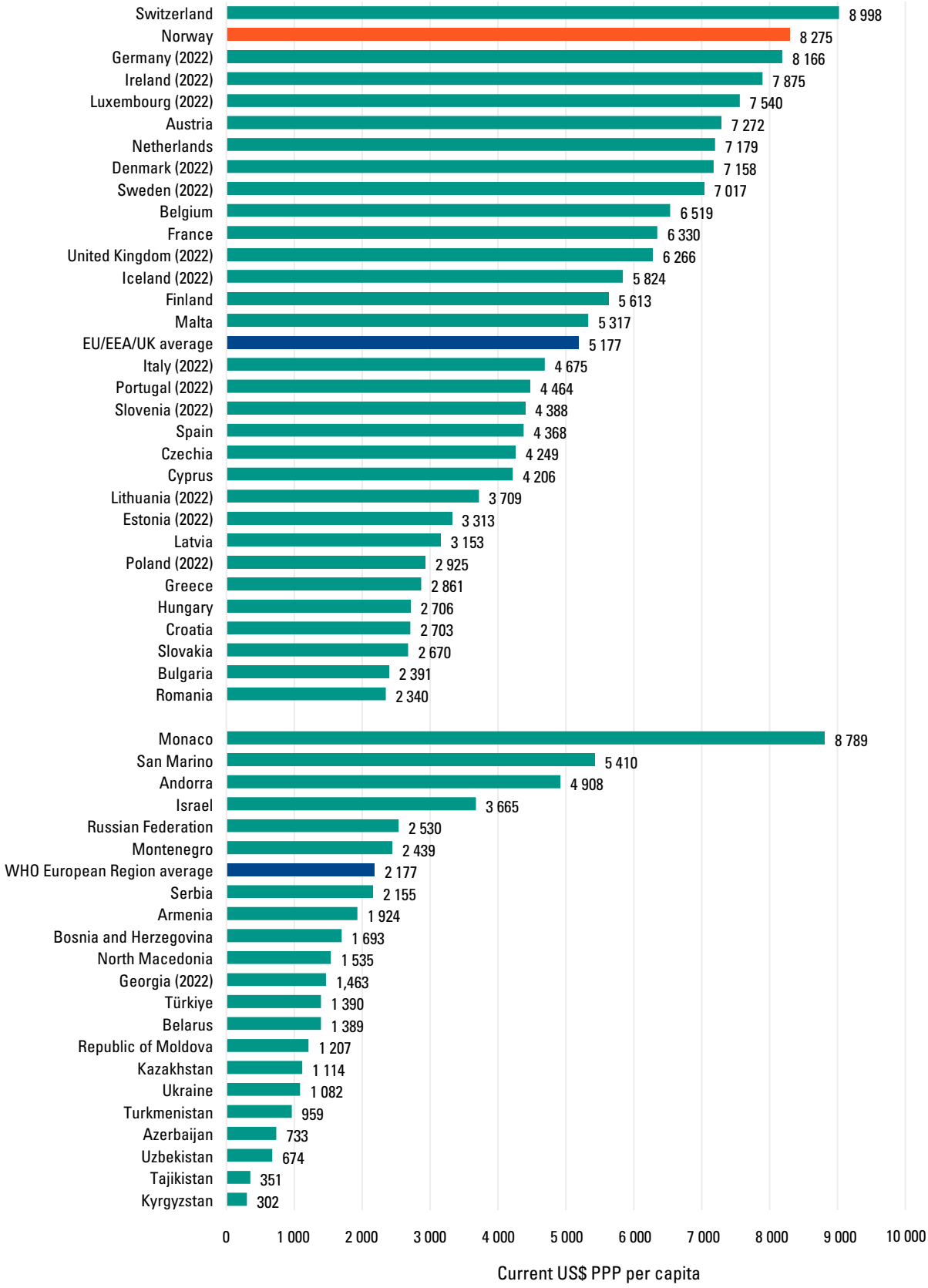
In Norway, more than 85% of health care expenditure is financed by the public sector, mainly through a government financing system supported by general taxation and the National Insurance Scheme (NIS), which is administered by a subordinate agency of the Ministry of Health and Care Services. The NIS is financed by contributions from employees, employers, and the government. The Ministry of Health and Care Services allocates the health budget among municipalities, counties, RHAs and the NIS using a distribution formula called the General Purpose Grant Scheme. This formula accounts for differences in structural costs and tax revenues. Specialized care is financed by the RHAs, which determine payment methods with providers. Primary health care is largely funded by municipal taxes, central government block grants, NIS contributions and patient co-payments.

Fig. 1 Trends in health expenditure in Norway, 2000–2021



Notes: GDP: gross domestic product; PPP: purchasing power parity.
Source: WHO, 2024.

Fig. 2 Current health expenditure in US$ PPP per capita in the WHO European Region, 2021 or latest year available



Notes: CHE: current health expenditure; EEA: European Economic Area; EU: European Union; PPP: purchasing power parity.

Source: WHO, 2024.

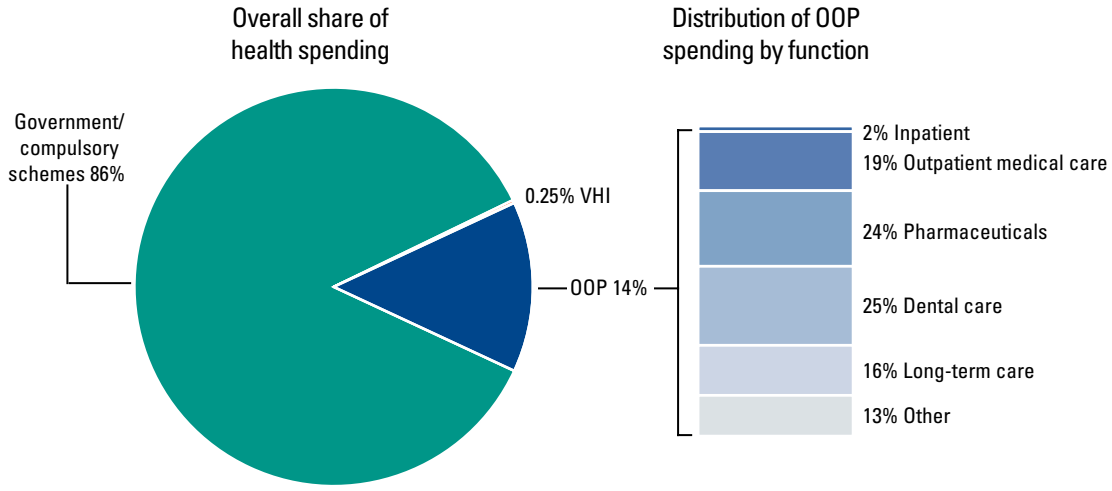
Health expenditure

Healthcare expenditure in Norway slightly decreased in 2021 but remains in the highest tier among countries in the World Health Organization (WHO) European Region, accounting for 10.1% of gross domestic product (GDP) (Fig. 1). In the same year, Norway's per capita spending on health was US$ 8275 (adjusted for differences in purchasing power), the third highest in the region, behind Switzerland and Monaco (Fig. 2). Public sources accounted for 85.9% of current health expenditure (CHE), which is the fourth highest share in Europe after Czechia, Luxembourg and Sweden. Private health expenditure is mostly composed of household out-of-pocket (OOP) payments, representing 98.3% of private expenditure on health, while the share of voluntary health insurance is negligible.

Out-of-pocket payments

Most publicly funded health services, including primary health care, require cost sharing. In 2021, OOP payments made up almost 14% of health spending. No cost sharing is required for inpatient care and long-term home-based nursing care but in other areas, cost sharing usually takes the form of co-payments and their level is set nationally. Exceptions are applied to certain diseases and groups of people. General dental care for adults and pharmaceuticals are areas where the share of OOP payments is particularly high (Fig. 3).

Fig. 3 Composition of out-of-pocket payments, 2021



Notes: OOP: out-of-pocket; VHI: voluntary health insurance.
Source: OECD, 2024.

Coverage

Health coverage is universal in Norway, available to any residents who plan to stay in the country for at least 12 months. The benefits package covers a broad range of services. Private health expenditure is low but mostly comes from households' OOP expenses, most of which is spent on pharmaceuticals, dental care and outpatient medical care (see Box 2). Co-payments are commonly required when consuming public health services, except for inpatient care. Since January 2021, there has been an annual cost-sharing ceiling to protect the population from excessive healthcare spending. User fees that count towards the annual ceiling include services such as consultations, treatments and imaging, but also services provided by therapists, such as physiotherapists and psychologists who have an agreement to supply services within the public sector.

Box 2 What are the key gaps in coverage?

Health coverage in Norway is fairly comprehensive and includes a broad range of services for all residents. Cost-sharing requirements are moderate on the whole, and the share of OOP spending as a share of current spending on health, at 14.1% in 2021, is among the lowest in the European Union (EU)/European Economic Area (EEA). There is a cost-sharing ceiling, which applies to most services and prescribed medications to limit total OOP costs, and other protection mechanisms are also in place. However, increasing costs of innovative medicines and the debate on their cost–effectiveness have been raising concerns about equitable access to medicines in the context of priority-setting. Dental care is another area where access may be obstructed by the limited public financing, which may lead to unmet needs for these services.

Paying providers

GPs are mainly paid through capitation payments from municipalities, which are included in the basic state funding allocated to municipalities; co-payments from patients; and fee-for-service payments from the Norwegian Health Economic Administration. Capitation payments are based on a fixed rate per patient considering a number of characteristics (age, gender, previous health service use, etc.) and account for about a quarter of a GP's total income. GPs with less than 1000 patients on their lists are eligible for additional funding to support their practice (Fig. 4).

Hospital care, as well as outpatient psychiatry and drug and alcohol abuse treatment, are financed equally by block grants and case-based funding from central government to the RHAs. Other types of specialist care are mainly funded through global budgets, with elements of case-based funding. In addition, from January 2022, the quality-based financing system has been replaced by the outcome-based system. The shortlist of outcome-based indicators is updated regularly.

Fig. 4 Provider payment mechanisms in Norway

GPs	Specialists	Acute hospitals	Hospital outpatient services	Dentists	Pharmacies
Capitation, fee-for-service, fixed budgets, co-payments	Fee-for-service, case payments, payment for quality, co-payments, fixed budgets	Fee-for-service, case payments, payment based on outcomes, fixed budgets	Fee-for-service, case payments, payment for quality, co-payments, fixed budgets	Fee-for-service	Fee-for-service

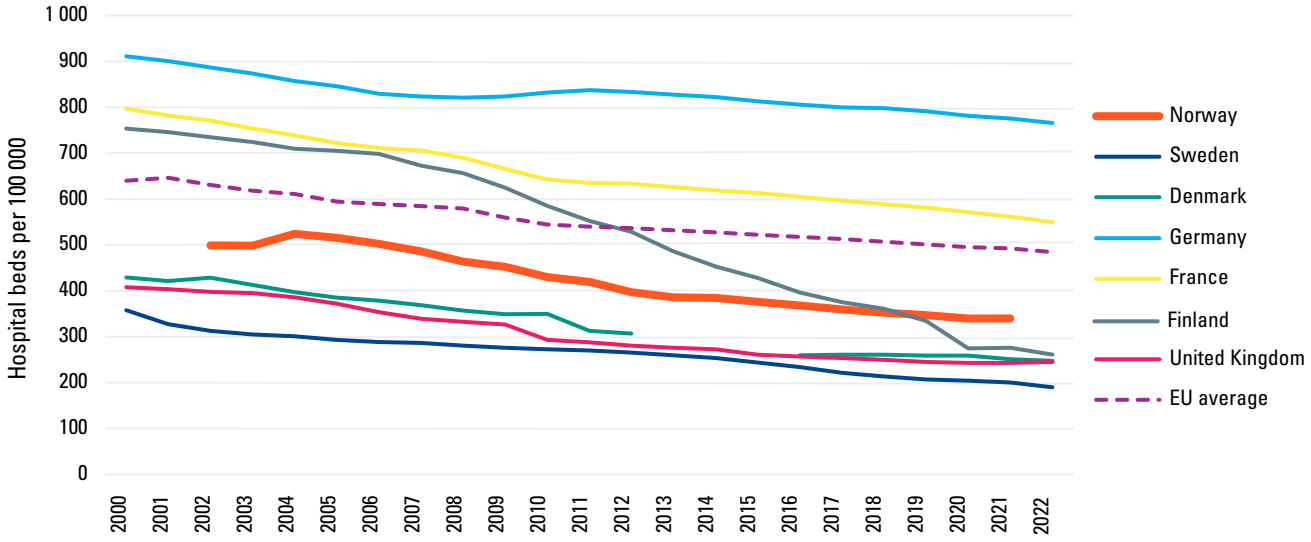
What resources are available for the health system?

Norway's health system is well-resourced overall but challenges linked to health workforce shortages remain.

Health infrastructure

Over the past 20 years, the number of hospital beds has steadily decreased, stabilizing at 340 beds per 100 000 population in 2020 and 2021 (Fig. 5). This development reflects government efforts to improve resource allocation by shifting inpatients to outpatient settings in the community and day surgery. Access to imaging diagnostic equipment is good, especially for magnetic resonance imaging (MRI) scanners, of which Norway has one of the highest densities per population in Europe (Fig. 6). The role of e-health has increased in recent years. For over 5 years, there has been a high use of electronic referrals from municipalities to hospitals, e-prescriptions, and telemedicine. Further efforts to develop digitalization of services are ongoing, for example, with the creation of National Data Service (*Helsedataservice*) supporting the Health, Demography and Quality of Life programme of the Nordic Councils of Ministers.

Fig. 5 Hospital beds per 100 000 population in Norway and selected countries, 2000–2022



Sources: Eurostat, 2024; OECD, 2024 for United Kingdom.

Health professionals

Among the highest in Europe, the number of practising doctors (516 per 100 000 inhabitants in 2021) in Norway has been increasing steadily since 2002 (Fig. 7a), as has the number of practising nurses (1832 per 100 000 in 2021), which is over twice the EU average (770 per 100 000) (Fig. 7b) and the highest among the EEA countries. Nevertheless, the nursing union reports that the use of temporary contracts is

Fig. 6 Magnetic resonance imaging (MRI) and computed tomography (CT) scanners in Norway, per 100 000 population, 2022

	MRI scanners per 100 000 population	CT scanners per 100 000 population
Norway	3.13	2.99
Lowest and highest in EEA (range)	0.56 (Hungary) - 3.73 (Greece)	1.07 (Hungary) - 4.88 (Greece)

Note: EEA: European Economic Area.

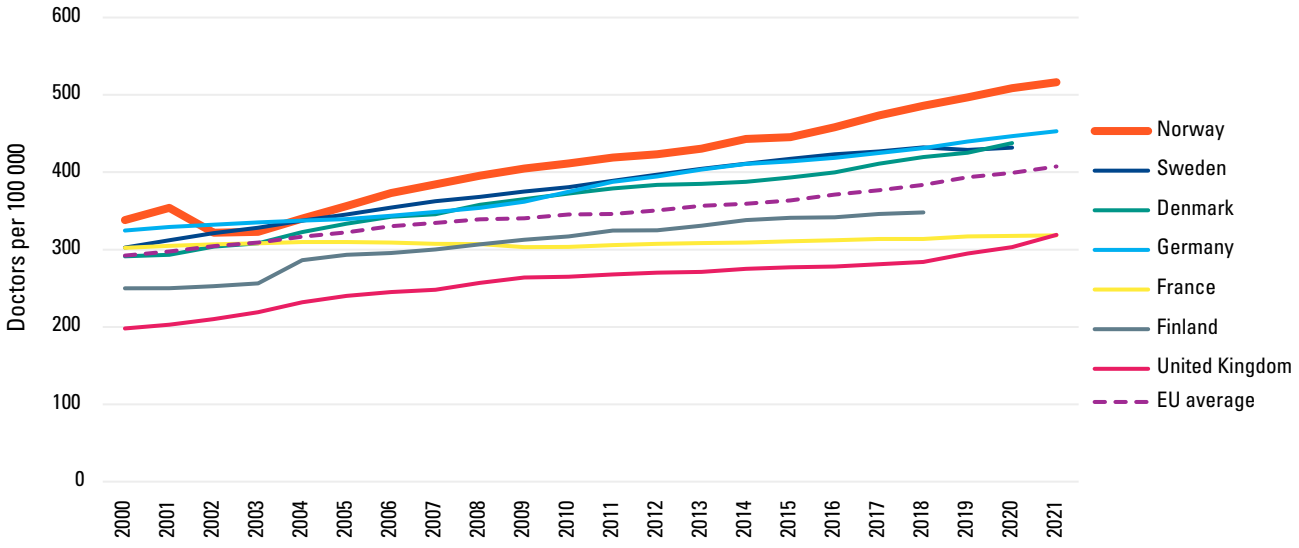
Source: Eurostat, 2024.

increasing, which in turn leads to nursing shortages and poorer work conditions (OsloEconomics, 2024). Despite remaining GP shortages in certain municipalities, Norway has achieved promising progress in tackling these. Expanding recruitment schemes of GPs in 2023 combined with a change in GP financing has led to a reduction in waiting times and an increase in the number of GP across municipalities; and further changes are foreseen for July 2025 (Box 3).

Distribution of health resources

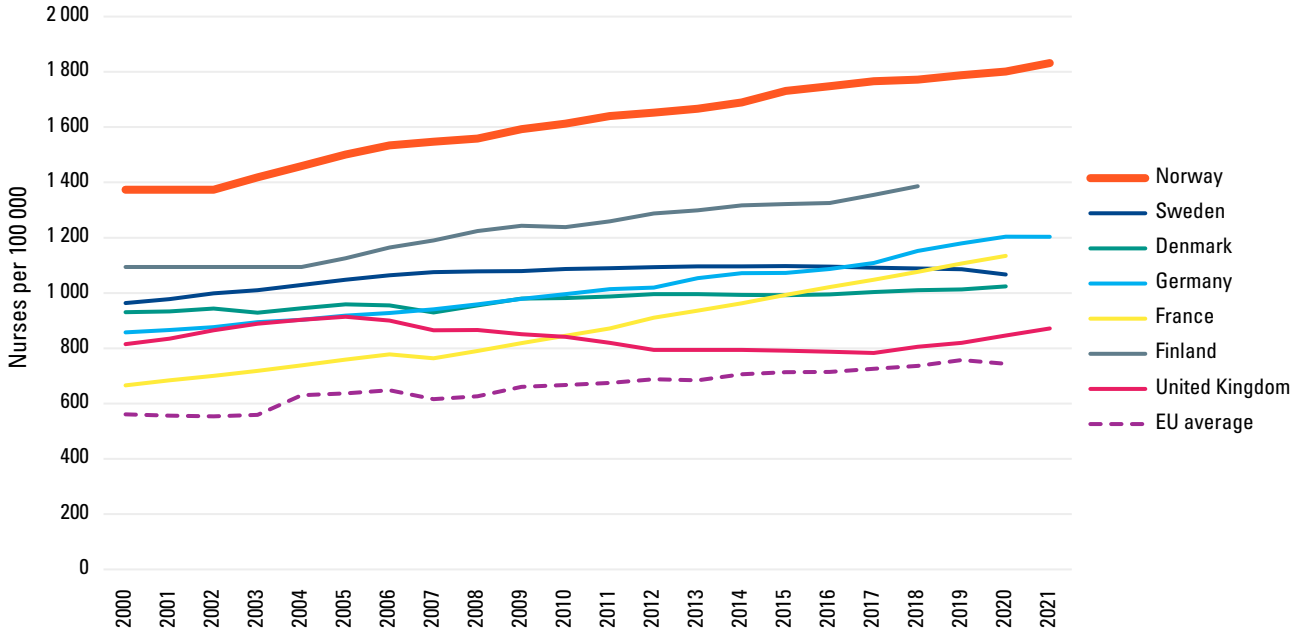
The size of hospital trusts varies from about 160 beds in the smallest trust (Sunnaas) to more than 1600 beds in the largest (Oslo University Hospital). The distribution of hospitals in Norway reflects the distribution of

Fig. 7a Number of physicians per 100 000 population in Norway and selected countries, 2000 to 2021



Sources: Eurostat, 2024; OECD, 2024 for United Kingdom.

Fig. 7b Number of nurses per 100 000 population in Norway and selected countries, 2000 to 2021



Sources: Eurostat, 2024; OECD, 2024 for United Kingdom.

the population, with the majority of hospitals located in the south-eastern region and the longest distances to the nearest hospital being in the northern region. Hence, a single trust can cover vast geographical areas; for example, the distance between hospitals within a single trust can exceed 500 kilometres in the county of Nordland. As a result, Norway still struggles to ensure equal access to health care across its entire territory, particularly in rural and sparsely populated areas.

There are also regional variations in access to GPs, with patients living in rural and smaller municipalities having poorer access; for example, seven municipalities had no GPs at the end of 2023. In three counties (Finnmark, Nordland and Møre & Romsdal), vacant GP positions have left 2–4% of their populations without a GP, and these vacancies are often longstanding.

How are health services delivered?

There are efforts to strengthen primary health care and to shift more services to the community.

Public health

In Norway, public health programmes are coordinated by the Ministry of Health and Care Services, with municipalities responsible for local implementation. Key agencies, such as the Directorate of Health and the Institute of Public Health, support national policy implementation and monitoring. Based on population

health status assessments, municipalities develop local strategies that address mental and physical disease prevention, social well-being and environmental conditions. They are also responsible for providing family planning and antenatal services, primarily through GPs, Healthy Life Centres, and school health services. Healthy Life Centres (HLCs), established in 1996, provide primary prevention services such as exercise groups and health counselling. Although not mandatory, 61% of municipalities had HLCs by 2023.

Major national health promotion initiatives include a long-standing tobacco control policy, a comprehensive alcohol policy and a national nutrition collaboration aimed at reducing unhealthy food intake. In March 2023, the Norwegian government published a white paper outlining the goals to promote public health and reduce health inequalities between socioeconomic groups. The paper focuses on key areas such as socially influenced health determinants, and equity in prevention of noncommunicable diseases, mental health, protection against health threats, and ensuring the right to a healthy environment. Among the latest actions was issuance of dietary advice for the population and general monitoring of municipalities activities in the area of public health.

Primary and ambulatory care

In Norway, the municipalities organize and provide primary health care services. These services include care provided by GPs, health centres, school health services, out-of-hours medical services, nursing homes, home-based care services, substance abuse services, physiotherapy, occupational therapy, speech therapy, chiropractors, HLCs and dental services.

Municipalities ensure that the necessary GP services are available. Residents are free to choose their GPs, who hold a gatekeeping function. GP practices typically consist of one to six doctors and do not include other health professionals such as nurses, physiotherapists or psychologists. In addition, municipalities are responsible for post-hospital discharge services, which include developing individualized treatment plans for patients with chronic illnesses and developing comprehensive patient pathways for those with multimorbidity and high care needs (Box 3).

To improve care coordination, follow up and monitoring of patients with chronic conditions, a new model of multidisciplinary primary care teams, which include nurses and health secretaries, was piloted from 2018 to 2023. The results of this pilot are currently under evaluation and will inform future policy development.

Box 3 What are the key strengths and weaknesses of primary care?

Strengthening primary care is high on Norway's political agenda. The ongoing reform of primary care aims to improve accessibility and coordination of care. Municipal responsibilities have been expanded to include more preventive health services, and primary care professionals other than GPs are to be authorized to supervise follow-up care for chronic patients (following pilots in 2018–2023). Despite these developments, access to GP services is uneven, with some municipalities facing GP shortages.

In 2022–23, the Norwegian Government conducted a comprehensive review of the GP system to examine its organization, financing and professional competencies. The review resulted in several recommendations to guide the future development of the workforce and primary care. These recommendations include expanding health professionals' roles and task sharing in primary care, promoting multidisciplinary care, integrating GP services with other municipal health services and improving working conditions and employment terms for GPs. The measures are intended to address existing challenges and improve the overall efficiency and effectiveness of the Norwegian primary health care system.

Hospital care

The provision of specialist care requires a referral from a GP and is the responsibility of the RHAs. Policy efforts have consistently sought to improve integration of care (Box 4) and to strengthen the provision of outpatient and day care services, with the goal of shifting away from costly inpatient care. Consequently, from 2015 to 2023, the number of outpatient consultations and day cases combined has increased on average by 17%, while the number of inpatient stays has decreased by 10% (Statistics Norway, 2024). The provision of treatments in somatic and psychiatric care and services for drug and alcohol addiction are increasingly being delivered in day-care settings. Furthermore, dialysis is performed and monitored largely at home with the help of telehealth communication.

Box 4 Are efforts to improve integration of care working?

In recent years, Norway has made efforts to improve care continuity and integration. Hospitals have been given greater responsibilities for coordinating discharges, including creating discharge checklists and requirements to coordinate post-discharge patient follow-ups with municipalities, often using digital services.

At the organizational level, the establishment of Healthcare Communities has further contributed to providing citizens with cohesive and coordinated health and care services from both hospitals and municipalities.

The national programme for welfare technology, which has been running since 2013, facilitated the implementation of innovative integrated care solutions on a large scale. The Regional Coordination Group for e-Health and Welfare Technology in Agder, Norway, played a pivotal role in this process with a project involving collaboration among 25 municipalities and hospitals in the region, and a focus on integrating welfare technology into health services.

The E-health Agder 2030 programme, introduced in 2020, includes initiatives such as TeleCare, digital home follow up and national e-health solutions. These initiatives aim to improve care coordination, follow up, and monitoring of patients with chronic conditions. The project's emphasis on building trust, enhancing digital competencies and fostering integrated care has positioned Agder as a leader in welfare technology in Norway (Rødseth et al, 2022).

Pharmaceutical care

Norway has relatively good access to pharmaceuticals, including innovative therapies. In 2022, prescription drugs accounted for over 90% of pharmaceutical consumption, with generics making up over 54% of the total volume. Pharmacies must offer patients at least one generic alternative at a price that is considerably lower than the maximum price. Furthermore, community pharmacies offer a range of extended services, including vaccination, inhalation guidance, and what is known as a new medicine service for patients with cardiovascular conditions and, as of 2023, diabetes. This new service consists of two follow-up consultations with a pharmacist after a new prescription (Norwegian Pharmacy Association, 2023).

Mental health care

In Norway, mental health care is provided through both primary care settings and hospitals, with municipalities organizing services. GPs are the first point of contact for adults, treating mild to moderate conditions and managing follow-up care for more severe cases. Access to specialized care upon GP referral is limited by the availability of mental health professionals. While municipalities are required to offer psychologist services, one in five failed to meet this mandate in 2023, particularly in rural regions.

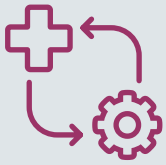
In the summer of 2023, the Norwegian government launched a 10-year Escalation Plan for Mental Health (2023–2033). The plan focuses on health promotion and prevention, accessible community-based

services, and specialized care for complex conditions. The goal is to improve mental health and quality of life, reduce mental distress, and provide accessible help across sectors. The plan emphasizes collaboration between the health, education and employment sectors.

Dental care

In Norway, the government provides free dental care for patients aged 18 years and under. Adults typically bear the financial responsibility for their dental care, with a few exceptions. In addition, certain dental procedures may be eligible for reimbursement through the NIS if performed by a provider with a contractual arrangement with Ministry of Health and Care Services. Most dentists (about 70%) operate in private practices where fees are not regulated. Unmet needs for dental care affected about 7.5% of the population in 2023, primarily due to cost, with a significant disparity between low- and high-income residents.

What reforms are being pursued?



Developing the health workforce and reducing waiting times are emerging as key areas for future reforms.

During the period of the previous National Health and Hospital Plan 2020–2023, significant changes were made to enhance the person-centeredness of the health system by improving care coordination between primary and specialist health service providers. A notable achievement was the establishment of 18 out of the 19 planned Healthcare Communities by 2022, which facilitated joint planning and coordination of care between health trusts and municipalities. Their activities are focused on the roles of primary healthcare and hospitals in improving health management of frail, elderly people, multimorbid patients, patients with mental health conditions and children. To support these efforts, numerous actions in strengthening primary care and public health were piloted and studied, with reforms initiated in 2015 (Box 5).

Norway has set out to address social health inequalities through intensified health promotion and disease prevention efforts, as outlined in the 2023 National Strategy for Equalizing Social Health Differences (*Folkehelsemeldinga*). It also prioritised the development of mental health prevention through the Escalation Plan for Mental Health (2023–2033), which includes cross-sectoral collaborations.

Furthermore, among other significant policy developments in Norway in 2022–2023 was a proposal to enhance the country's preparedness for crises through the adoption of recommendations from the report "Resilient health preparedness in a new era: from pandemic to war in Europe". This includes the establishment of robust, flexible and scalable systems to respond to crises and the implementation of a new model for health emergency preparedness with clarified roles and responsibilities for the health and care sector (Ministry of Health and Care Services, 2023).

Future reforms will focus on achieving the objectives of the National Health and Cooperation Plan 20242027 ("Our Joint Health Service") through workforce development, reducing waiting times, and continuing the digitalization of health services.

Box 5 Key health system reforms over the past 15 years

2012: Coordination Reform to improve coordination of care between municipalities and hospitals, and to strengthen public health (implemented).

2014: Choice Reform to extend patient choice of treatments and providers to include all private providers (implemented and amended in 2023 to include only contracted private providers).

2015: Competence Shift 2020 to adapt education and training in primary care to future health needs (under implementation).

2019: Implementation of Healthcare Communities to formalize governance structures between the municipalities and specialist care to improve joint planning of services and strengthen care coordination (implemented).

2020, 2024: National Health and Hospital Plans 2020–2023 and 2024–2027 to set objectives in improving provision of healthcare; ensuring the right volume and skill mix of health workforce; improving coordination between levels of care and strengthening outpatient care; continuing the digitalization of health services; and improving accessibility of services and reducing waiting times (under implementation).

2023: Escalation Plan for Mental Health (2023–2033) to prioritize mental health promotion and prevention, improving accessibility of community-based services and specialized care for complex conditions (under implementation).

2023: Resilient health preparedness (2023): new model for health emergency preparedness (under implementation).

How is the health system performing?

Norwegian health outcomes are among the best in Europe, but primary health care efficiency and equity in financial protection could be further improved.

Health system performance monitoring and information systems

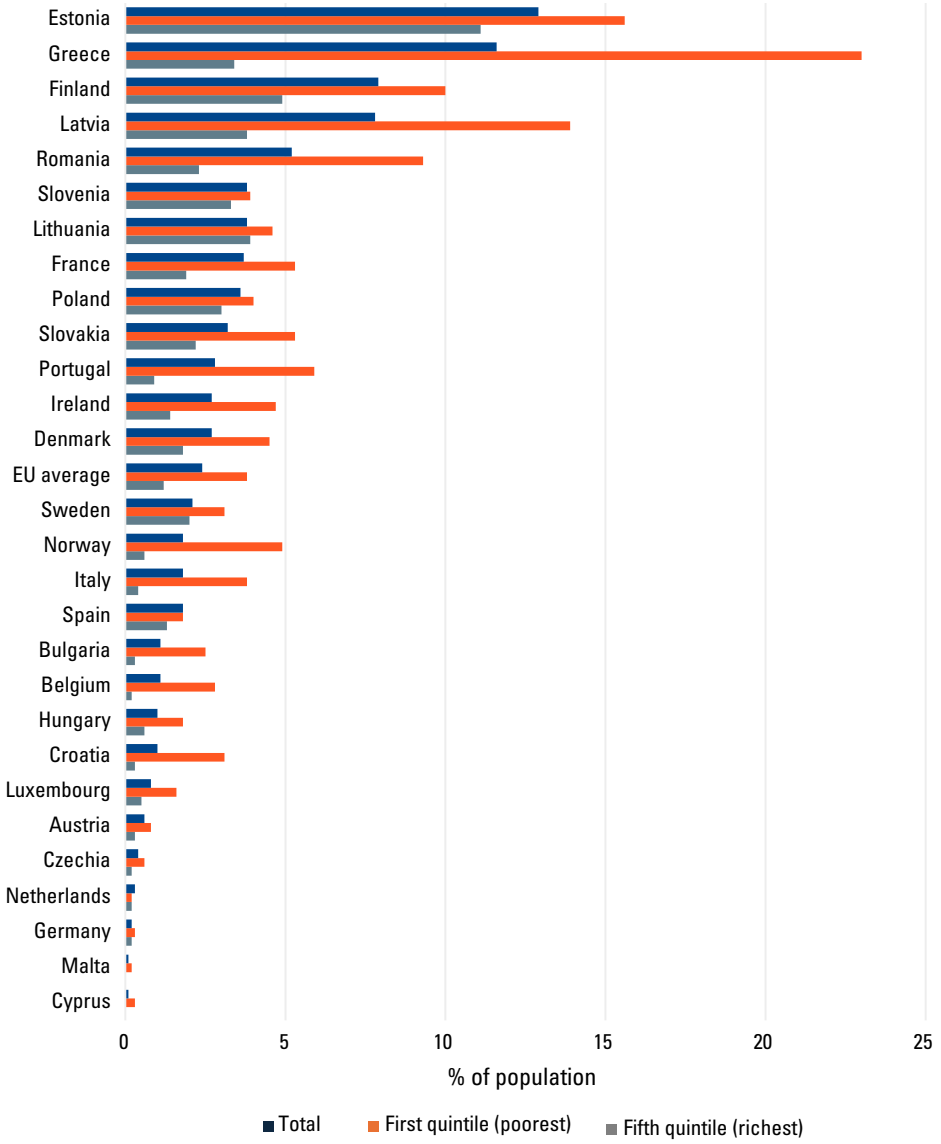
For the past few decades, improving transparency in the Norwegian healthcare system has been a political priority. Public monitoring of performance indicators in policy processes has improved and has been used more widely. Municipalities, health trusts and state agencies provide data to Statistics Norway. Public reporting on hospital resources is systematic and has included information on patient experiences and mortality after hospitalization for over 25 years. A database (KOSTRA) provides comparative data on health and social care services at the municipality level. Since 2014, the National Quality Indicator System, developed, maintained, and disseminated by the Directorate of Health, supports healthcare users and their relatives in making informed choices about their healthcare providers; informs the public about the quality of healthcare services; and generates data to support management and quality improvement in healthcare. The Directorate of Health also publishes annual SAMDATA reports, which consist of a collection of comparative statistics and performance indicators on specialist care, including mental health care for hospital trusts and at the municipal level.

Accessibility and financial protection

Access to healthcare to all in need is a fundamental social right in Norway and ensuring universal and equitable access to healthcare is embedded in the Patients' Rights Act of 1999. The Norwegian health system offers a high level of social and financial protection. Various mechanisms, such as exemptions and ceilings on OOP payments, limit the financial burden of care on individuals. Nevertheless, the level of protection is poor for certain types of care, such as adult dental care and home-based or institutional services for older and disabled people, and important gaps remain between the poorest and the richest income quintile.

Following the COVID-19 pandemic, unmet need for medical examination rose, from 1% in 2019 to 1.8% in 2023, but remained under the EU average (2.4%) (Fig. 8). However, Norway records a wider gap between the poorest and the richest income quintile (4.9% and 0.6%, respectively) compared with the EU averages (3.8% and 1.2%). Unmet need for dental care is one of the highest in Europe (7.5%), twice the EU average (3.4%), and also with a significant gap between the poorest and richest income quintiles (15.9% and 2.3%).

Fig. 8 Unmet needs for a medical examination (due to cost, waiting time or travel distance), by income quintile, EU, 2023



Note: EU: European Union.

Source: Eurostat, 2024.

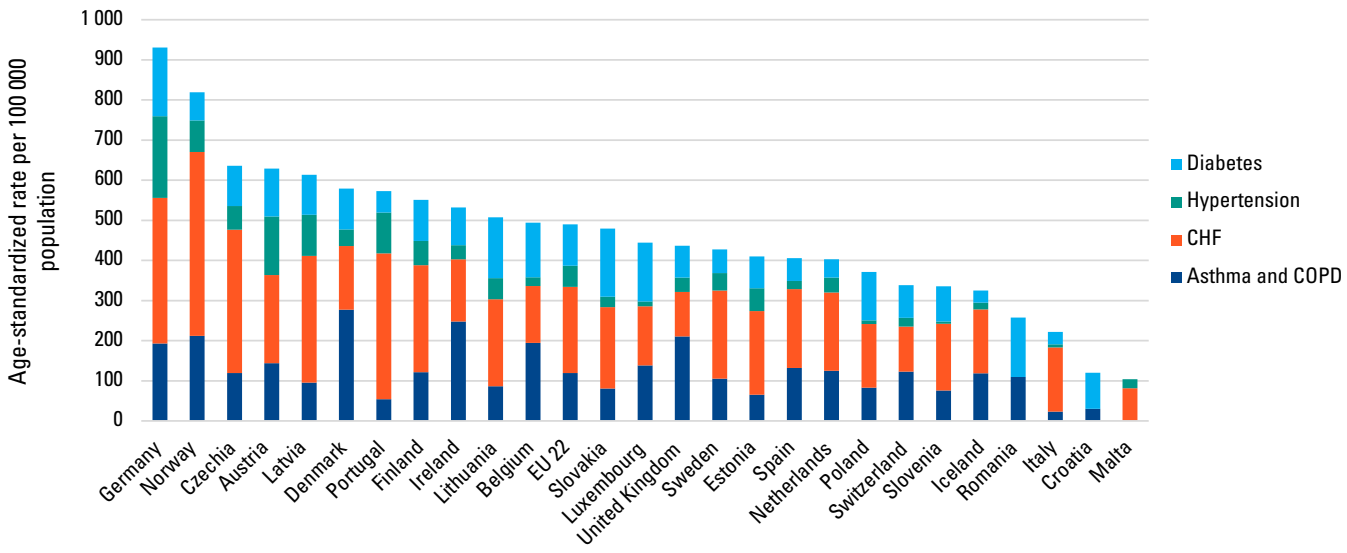
Health care quality

Norway records the third highest level of hospital admissions for chronic obstructive pulmonary disease (COPD) and average levels of hospital admissions for certain conditions such as asthma, congestive heart failure (CHF), hypertension and diabetes (conditions that can generally be managed outside of hospital) compared with other EEA countries. For example, in 2021, Norway's rate of avoidable hospital admissions for these conditions combined was the second highest after Germany (Fig. 9), which may indicate inefficiencies and/or weaknesses in primary health care.

Regarding the effectiveness of inpatient care, Norway has among the best outcomes in terms of mortality from acute myocardial infarction (AMI), haemorrhagic stroke, and ischaemic stroke within 30 days of hospitalization (Fig. 10) and managed to consistently reduce these rates for the past decade. The survival gains seen for stroke are partly attributable to patient care pathways for stroke developed between 2017 and 2019, alongside initiatives to raise awareness around early symptoms and signs of stroke among the population, which enabled more rapid and timely access to care. The National Strategy on Brain Health (2018–2024) aims to further improve stroke care and reduce geographical variations in access to post-stroke rehabilitation services.

For almost 25 years, Norway has been conducting patient experience surveys, providing information on the quality and responsiveness of the Norwegian health system (see Box 6).

Fig. 9 Avoidable hospital admission rates for asthma and chronic obstructive pulmonary disease, congestive heart failure, hypertension and diabetes, 2021

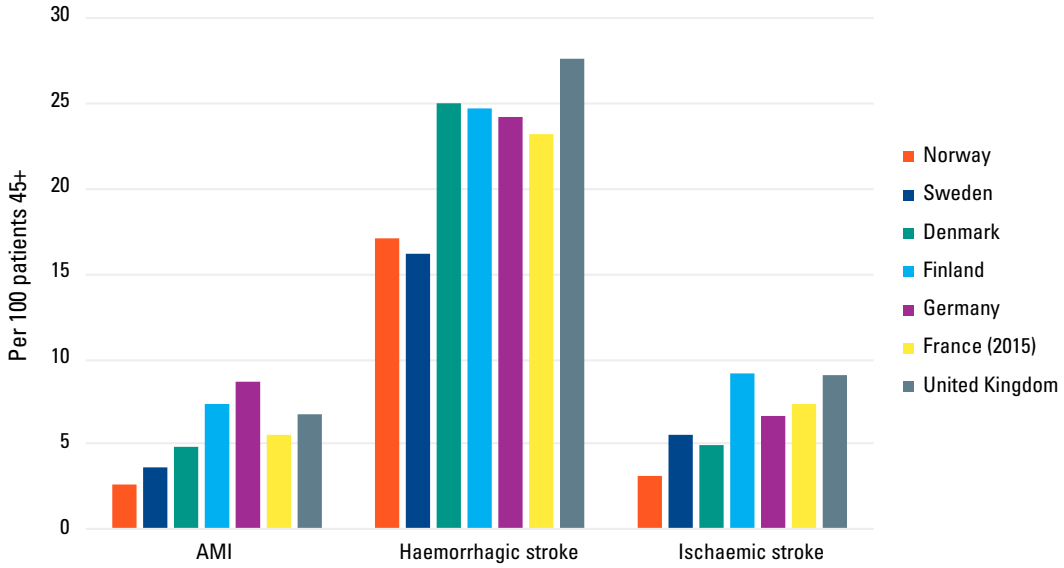


Notes: CHF: congestive heart failure; COPD: chronic obstructive pulmonary disease. Croatia and Romania: no data for CHF or hypertension; Malta: no data for asthma & COPD or diabetes.
Source: OECD, 2024.

Health system outcomes

The health status of the Norwegian population remains very good by international standards and has improved consistently over the last few decades. Preventable mortality corresponds to deaths from causes that could be avoided through public health policies, such as chronic liver disease, road traffic injuries and lung cancer (see Box 7). Mortality from treatable causes, or premature deaths that could be avoided with timely

Fig. 10 In-hospital mortality rates (deaths within 30 days of admission) for admissions following acute myocardial infarction, haemorrhagic stroke and ischaemic stroke, Norway and selected countries, 2021 (or latest year available)



Note: AMI: acute myocardial infarction.

Source: OECD, 2024 (data refer to 2021 unless otherwise stated).

Box 6 What do patients think of the care they receive?

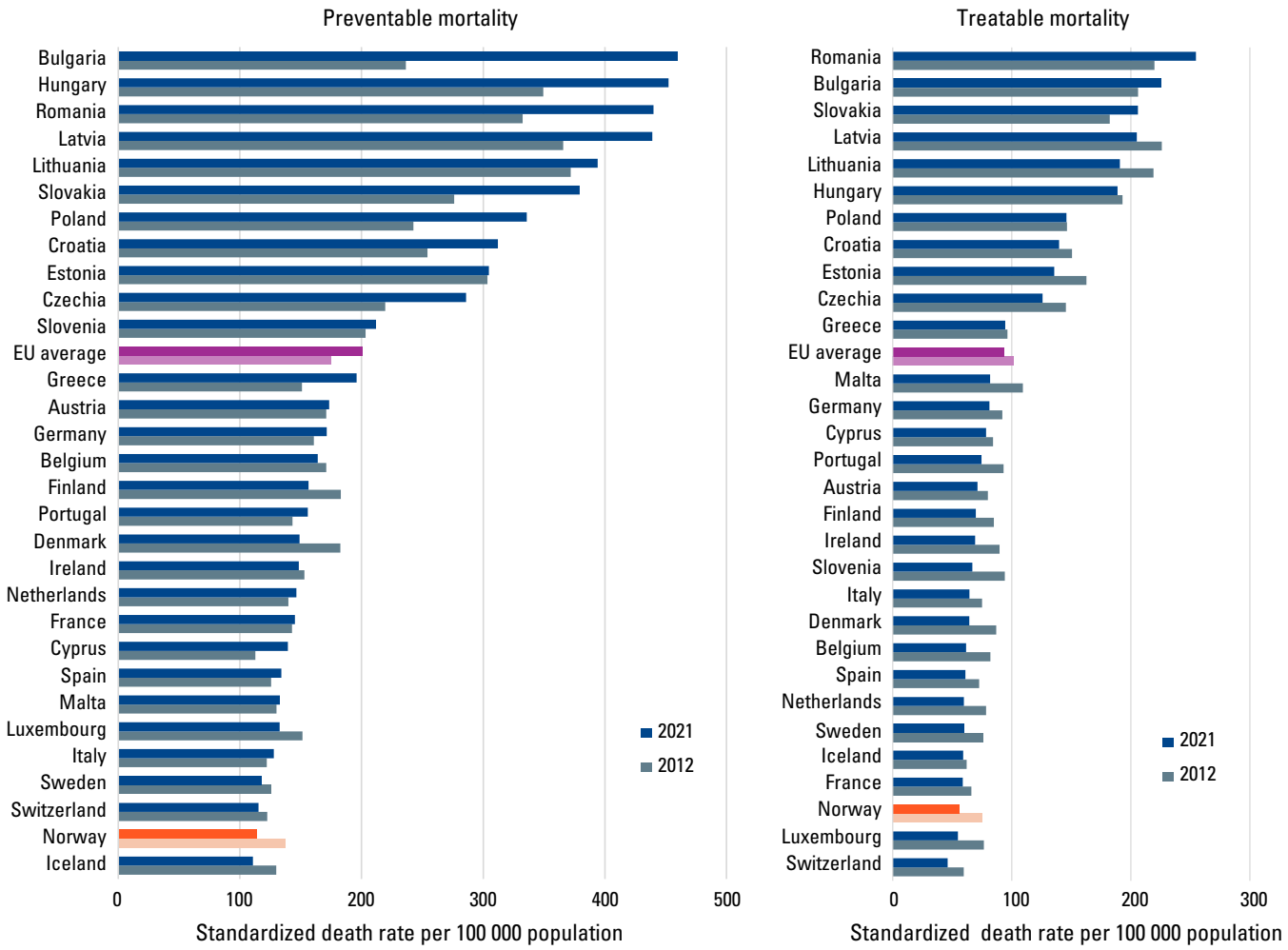
Since the early 2000s, Norway has had a national programme to measure patient experience (patient-reported experience measures, PREMs) in secondary health care, and has conducted more than 30 national surveys to date. While the programme focuses primarily on secondary care, it also includes several surveys related to municipal health and care services. These include national surveys on patients' experiences of GPs and the OECD's Patient-Reported Indicator Survey (PaRIS) on patients with chronic conditions, in which Norway participates. In 2023, Norway's public health administration underwent a reorganization that resulted in the PREMs measurement programme being transferred from the Norwegian Institute of Public Health (NIPH) to the Norwegian Directorate of Health as of 1 January 2024.

Over time, patients' experience of hospital care has shown improvement. In 2020, patients rated their experience with physicians and nurses the highest, with the least variation in scores between hospitals. The lowest scores were for discharge processes.

and effective health care, is used as an indicator of the contribution that health care makes to improve population health.

Fig. 11 shows preventable and treatable mortality rates across the EU/EEA in 2012 and 2021, and for both, Norway ranks among the countries with the lowest rates in Europe. Between 2012 and 2021, preventable mortality decreased from 137.1 to 113.9 deaths per 100 000, despite the impact of the COVID-19 pandemic, which caused an increase in preventable mortality rates in most European countries in 2020 and 2021. Over the same period, treatable mortality in Norway decreased by over 20 points, from 74.7 to 55.6 deaths per 100 000 inhabitants. Part of Norway's low levels of treatable mortality may be attributed to a large reduction in mortality from ischaemic heart disease and increased rates of survival from some treatable cancers, which reflects both widespread screening programmes and improved diagnostics and treatment.

Fig. 11 Mortality from preventable and treatable causes, 2012 and 2021



Notes: EU: European Union. After 2020, deaths due to COVID-19 are counted as preventable deaths, resulting in an increase in mortality from preventable causes for most countries.

Source: Eurostat, 2024.

Box 7 Are public health interventions making a difference?

For more than 50 years, Norway has implemented targeted tobacco control measures, including high tobacco taxes, mandatory health warnings on packaging and restrictions on smoking in public places. Smoking has been restricted in public places since 1988 and banned in all indoor public places since 2004. While these policies have been successful in reducing smoking rates, vaping has become increasingly popular over the past two decades. In response, the latest regulation on tobacco products (introduced in November 2023) tightens restrictions on e-cigarettes, requiring standardised packaging and banning flavoured products.

In 2015, the National Strategy against Antibiotic Resistance for 2015–2020 was launched to reduce the use of antibiotics in the health sector by 30% by 2020. From 2013 to 2022, there was a notable decline in the consumption of antibacterials for systemic use in the community and within the hospital sector, with an average annual reduction of 1% (measured as defined daily doses (DDD) per 1000 inhabitants per day). In 2022, the hospital sector in Norway recorded 1.24 DDDs per 1000 inhabitants per day, which was lower than the EU/EEA average of 1.61 DDDs. In the community, Norway used 14 DDDs, also below the EU/EEA average of 17 DDDs. These figures reflect some success in reducing antibacterial usage (ECDC, 2022). Use of antibiotics in animals in Norway is among the lowest in Europe and is partly explained by the effective use of vaccines in aquaculture that has reduced its antibiotics by 99% since 1987.

Box 7 (Continued)

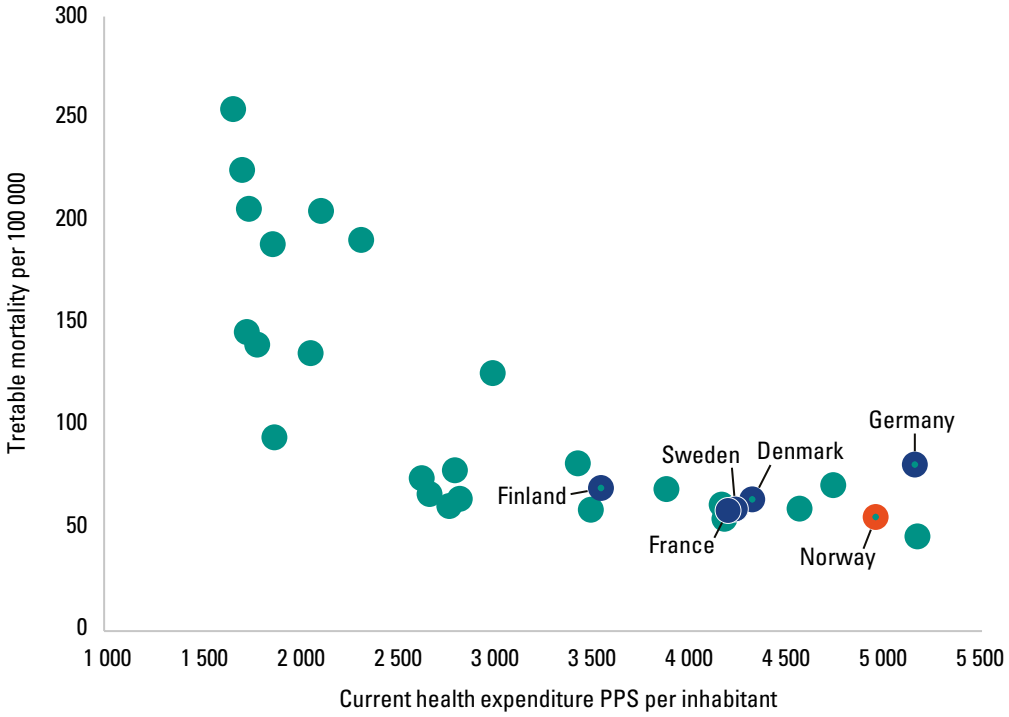
The 5-year survival rate for breast cancer in Norway is among the highest in the world, reflecting both earlier diagnosis in some cases and effective treatment once diagnosed. Immunization rates in children have been increasing and the vast majority of children and young people are vaccinated against the diseases recommended in the Norwegian Childhood Immunization Programme.

Health system efficiency

Various actors at both central and local levels influence allocative efficiency in Norway's health sector. At the central level, the amounts allocated from the Ministry of Health and Care Services to the lower levels account for population needs, including the number of inhabitants living in the region, their age and income, and the levels of service use (in the case of allocation to the RHAs).

A very cursory way of illustrating how the health system is performing in terms of input costs and outcomes is to plot current expenditure on health against the rate of treatable mortality. On this metric, while Norway achieves very low levels of mortality from treatable causes, there are clusters of other countries that have a similar outcome but which spend comparatively less than Norway (Fig. 12). Nevertheless, a report from the OECD Health Division, commissioned in 2016 by the Ministry of Health and Care Services to examine how health spending in Norway compares with other relevant high-income OECD countries, concluded that the country's high spending is in line with its wealth and demographic structure.

Fig. 12 Treatable mortality per 100 000 population versus health expenditure per inhabitant, Norway and selected countries, 2021



Note: PPS: purchasing power standard.

Source: Eurostat, 2024.

In terms of technical efficiency, like many other European countries, Norway has sought to shift some inpatient care towards outpatient settings, leading to a decrease in the number of hospital beds, a shorter length of hospital stay, and wider use of day surgery. One area for potential efficiency gains is pharmaceuticals and the use of less expensive medicines (Box 8).

Box 8 Is there waste in pharmaceutical spending?

Generic substitution was introduced to pharmacies in 2001 and has led to a reduction in the cost of pharmaceuticals financed through the NIS. The generics share of the pharmaceutical market rose steeply until 2008 and then stabilized between 2009 and 2014. In late 2018 Norway and Denmark established a joint initiative to further promote the use of generics and increase the market share of biosimilars. Since then it has been rising again and in 2021 sales of generic medicinal products accounted for 55.4% of total sales, measured in terms of volume, compared with 23.6% in 2001 and 41.5% in 2011.

Uptake of low-cost statins has been increasing in Norway. Atorvastatin is the top-selling statin and accounted for 73% of the statins market in terms of defined daily doses (DDDs) per 1000 population per day in 2020. Norway has also been at the forefront of increasing biosimilars uptake, for example, via the NOR-SWITCH trial, which aimed to test the safety of switching patients from the originator biological product with its biosimilars. The rationale behind the use of biosimilars is to increase price competition, thereby reducing pharmaceutical prices.

Summing up

Norway has a well-performing health system and aims to further strengthen its resilience to future crises.

Norway has a well-performing health system and the level of self-reported unmet medical need is very low. Norwegians live longer and healthier lives than most other Europeans, with the gains over recent decades partly attributable to effective and high-quality preventative measures and treatment. Challenges remain to make the health system more equitable and primary healthcare more efficient. Norway is working on further strengthening primary and community care, notably by addressing GP shortages, as well as tackling inequalities in accessing healthcare and intensifying health promotion and disease prevention efforts. The health policy agenda is also geared to enhancing emergency preparedness for future crises and on achieving the objectives of the National Health and Cooperation Plan 2024–2027 ("Our Joint Health Service") which targets the development of the health workforce, reducing waiting times, and continuing the digitalization of health services.

Population health context

Key mortality and health indicators

Life expectancy (years)	2023
Life expectancy at birth, total	83.1
Life expectancy at birth, male	81.6
Life expectancy at birth, female	84.7
Mortality	**2021**
All causes (SDR per 100 000 population)	832.27
Circulatory diseases (SDR per 100 000 population)	208.14
Malignant neoplasms (SDR per 100 000 population)	219.54
Communicable diseases (SDR per 100 000 population)	19.12
External causes (SDR per 100 000 population)	51.71
Infant mortality rate (per 1 000 live births)	1.9
Maternal mortality per 100 000 live births (modelled estimates)*	1.7

Notes: SDR: standardized death rate; * Maternal mortality data is for 2020.
Sources: Eurostat, 2024; WHO Regional Office for Europe, 2024.

References

ECDC (2022). Antimicrobial consumption in the EU/EEA (ESAC-Net). Annual epidemiological report for 2022. Surveillance report. Solna: European Centre for Disease Prevention and Control (https://www.ecdc.europa.eu/sites/default/files/documents/AER-antimicrobial-consumption.pdf), accessed 5 October 2024.

Eurostat (2024). Eurostat Database. Luxembourg: European Commission.

Government of Norway (2024). Nasjonal helse- og samhandlingsplan 2024–2027: Kortere ventetider og en felles helsetjeneste [National health and cooperation plan 2024–2027: Shorter waiting times and a common health service]. (https://www.regjeringen.no/no/aktuelt/nasjonal-helse-og-samhandlingsplan-2024-2027-kortere-ventetider-og-en-felles-helsetjeneste/id3028011/), accessed 18 June 18 2024 (in Norwegian).

Ministry of Health and Care Services (2023). A resilient health emergency preparedness: from pandemic to war in Europe. Meld. St. 5 (2023-2024) Report to the Storting (white paper) (https://www.regjeringen.no/contentassets/3c8d4417eb584c8e821201b644392c51/en-gb/pdfs/stm202320240005000engpdfs.pdf), accessed 18 June 2024.

Ministry of Local Government and Regional Development (2023). NOU 2023: 9 System of Generalist Municipalities. Official Norwegian Report (NOU 2023: 9) to the Government. (https://www.regjeringen.no/en/dokumenter/nou-2023-9/id2968517/), accessed 18 June 2024.

Norwegian Pharmacy Association (2023). Key figures 2023: pharmacies and pharmaceuticals in Norway (https://www.apotek.no/Files/Filer_2014/Engelske_sider/Key%20figures%202023.pdf), accessed 18 June 2024.

OECD (2024). OECD Health Statistics. Paris: OECD Publishing.

OsloEconomics (2024). Evaluering av tiltak i allmennlegetjenesten. Evalueringsrapport III, 2024 [Evaluation of measures in the general practitioner service. Evaluation Report III, 2024] Oslo: OsloEconomics, Universitetet i Oslo. (https://osloeconomics.no/wp-content/uploads/2024/05/HPA-evalueringsrapport-III-2024-%E2%80%93-oppdatert.pdf), accessed 5 October 2024 (in Norwegian).

Rødseth E, Yabsley AJ, Kristiansen TT, Bjørvig S (2022). Integrated healthcare and Care through distance spanning solutions: for increased service accessibility. Stockholm: Nordic Welfare Centre. (https://nordicwelfare.org/pub/Integrated_Healthcare_and_Care_through_distance_spanning_solutions_v4/joint-health-care-effort-ensures-welfare-technology-integrated-into-services.html), accessed 18 June 2024.

Statistics Norway (2024). StatBank. Oslo: Statistics Norway (https://www.ssb.no/statbank), accessed 18 June 2024

WHO (2024) Global health expenditure database. Geneva: World Health Organization.

WHO Regional Office for Europe (2024). European Health for All database (HFA-DB). Copenhagen: WHO Regional Office for Europe.

Keywords:
DELIVERY OF HEALTH CARE
EVALUATION STUDIES
FINANCING, HEALTH
HEALTH CARE REFORM
HEALTH SYSTEM PLANS – organization and administration
NORWAY

© World Health Organization, 2024 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the WHO and the European Observatory on Health Systems and Policies or any of its Partners concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the WHO or the European Observatory on Health Systems and Policies or any of its Partners in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters. All reasonable precautions have been taken by the European Observatory on Health Systems and Policies to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied.

The responsibility for the interpretation and use of the material lies with the reader. In no event shall the WHO, the European Observatory on Health Systems and Policies or any of its Partners be liable for damages arising from its use. The named authors alone are responsible for the views expressed in this publication. The views and opinions expressed in Observatory publications do not necessarily represent the official policy of the Participating Organizations.

The European Observatory on Health Systems and Policies is a partnership that supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health systems in the European Region. It brings together a wide range of policy-makers, academics and practitioners to analyse trends in health reform, drawing on experience from across Europe to illuminate policy issues. The Observatory's products are available on its web site (http://www.healthobservatory.eu).