This Health System Summary is based on the *Norway: Health System Review* (HiT) published in 2020 and relevant reform updates highlighted by the Health Systems and Policies Monitor (HSPM) ([www.hspm.org](http://www.hspm.org)). For this edition, key data have been updated to those available in March 2022 to keep information as current as possible. 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.


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How is the health system organized?

ORGANIZATION

Norway has a semi-decentralized health system with four Regional Health Authorities that are responsible for specialist care and municipalities that are responsible for primary care and social services. The 2012 Coordination Reform introduced formal contracts between the municipalities and the health trusts (owned by the Regional Health Authorities) to improve the coordination of specialist and primary care. Since 2019, this has been supported by the introduction of a network of Healthcare Communities, which provide governance structures for joint planning of services between the municipalities and the health trusts. In addition, counties play a role, including in provision of dental care (until 2023), safeguarding access to services and serving as appeal bodies to municipal decisions, and, increasingly, in coordination of care and provision of public health services.

PLANNING

The Ministry of Health and Care Services, with the help from its subordinate agencies, is responsible for the planning, regulation and supervision of the health system and ensures that health and social services are provided in accordance with national legislation and regulations (see Box 1). The National Health Plans are the key strategic planning tools in the health sector. They are developed by the Ministry of Health and Care Services with a usual planning horizon of 4 years and present the current status of the health care system, including the key challenges, and suggest policy goals and measures aimed at meeting them.

PROVIDERS

Most general practitioners (GPs) are self-employed and work under contract with the municipalities. Specialized outpatient care is usually provided in hospital outpatient departments called polyclinics. Inpatient specialized care is mainly provided by hospital trusts owned by the four Regional Health Authorities.

BOX 1 | EVALUATING PRIORITY SETTING AND PLANNING

Five government commissions have evaluated the principles for priority setting in the health care sector over the last 30 years, most recently in 2018, with the first evaluation report targeting prioritization principles for municipal health and care services and publicly funded dental health services. The report concluded that the existing principles for priority setting in specialist care were suited for municipal services, but should incorporate assessment of individual patients’ physical, psychological and social functioning.

Between 2002 and 2017 the National Council for Priority Setting in Health Care advised the government on public health issues and on issues of relevance to the health system as a whole. The objective of the Council was to contribute to a more comprehensive approach to priority setting in health and care services and fed into a shared understanding of the current situation and problems among key actors within health and care services. The Council also contributed to the establishment of a National System for the Managed Introduction of New Health Technologies within the Specialist Health Service and a more systematic use of Health Technology Assessment (HTA) as a basis for prioritization in the health sector.
How much is spent on health services?

FUNDING MECHANISMS

Health financing in Norway comes predominantly from public sources, consisting of transfers from the general government (national, county and municipal tax revenues) (76%) and from the National Insurance Scheme (10%). National taxes are used to finance provision of secondary care and partly provision of primary care, while municipal taxes are the main source of funding for primary care. The Norwegian tax system is largely progressive, with most of the tax revenue coming from direct taxes and with the average tax burden increasing with higher income. The National Insurance Scheme is financed from insurance contributions by its members (32%), payroll (40%) and national (28%) taxes.

HEALTH EXPENDITURE

Health care expenditure accounted for 10.5% of gross domestic product (GDP) in 2019 (Fig. 1) – the sixth highest in the World Health Organization (WHO) European Region. With Norway’s per capita GDP being one of the highest in the world, the country’s per capita health expenditure is also much higher than in most countries – over US$ PPP 7,217 (adjusted for differences in purchasing power), second only to Switzerland (Fig. 2). Public sources account for 85.8% of current health expenditure, which is the highest share in Europe.

FIG. 1  TRENDS IN HEALTH EXPENDITURE, 2000–2019 (SELECTED YEARS)

Note: PPP: purchasing power parity.
Source: Global health expenditure database, December 2021.

Norway spends more on health than most other countries and the vast majority of it comes from public funds.
Fig. 2  Current Health Expenditure (US$ PPP) Per Capita in WHO European Region Countries, 2019

Notes: CHE: current health expenditure; PPP: purchasing power parity.
Data for Albania are from 2018.
Source: Global Health Expenditure Database, December 2021.

Out-of-Pocket Payments

Most publicly funded health services, including primary care, require cost-sharing. In 2019, out-of-pocket payments (OOPs) made up almost 14% of health spending (Fig. 3). 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 for certain diseases and groups of people. General dental care for adults is one area where the share of OOPs is very high (approximately 70% of total spending on dental care).
COVERAGE

Health coverage among Norwegian residents is universal, covering the whole population, and the benefit basket covers a broad range of services. Most private health financing comes from households' OOPs, of which most is spent on pharmaceuticals, dental care and long-term care (Box 2). There are annual cost-sharing ceilings to protect the population from excessive health care spending. Until 2021, two separate annual spending caps applied: for physician and psychologist visits and prescription medicines (Ceiling 1); and another for physiotherapy, rehabilitation and (some) dental care (Ceiling 2). In January 2021, these caps were merged and set at the level equivalent to Ceiling 1. This change will benefit patients with high health care needs because payments previously made under ceilings 1 and 2 will both count towards the new cap, resulting in reduced spending for the patient as the cap will be reached sooner.

BOX 2 | ASSESSING COVERAGE

Health coverage in Norway is fairly comprehensive and includes a broad range of services for residents. Cost-sharing requirements are moderate on the whole, and the share of OOP spending as a share of current spending on health, at just under 14% in 2019, is among the lowest in the European Union (EU)/European Economic Area (EEA) (although in monetary terms it is among the highest, given Norway’s high per capita GDP). Cost-sharing ceilings apply to most services and prescribed medications to limit OOP costs and other protection mechanisms are also in place. However, increasing costs of innovative medicines have been raising concerns about equal access to medicines in the context of debates on 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

Primary care is financed from municipal taxes, block grants from the central government and earmarked grants for specific purposes; a major funding source for primary care is also the National Insurance Scheme, as well as patient co-payments (Fig. 4).

Hospital care, as well as outpatient psychiatry and treatment of drug and alcohol abuse, is financed in equal parts through block grants and case-based financing from the central government to the Regional Health Authorities. Other types of specialist care are mainly financed through global budgets, with elements of case-based funding. Quality-based funding is currently marginal but is being rolled out at the national level.

FIG. 4 | PROVIDER PAYMENT MECHANISMS IN NORWAY

<table>
<thead>
<tr>
<th>GPs</th>
<th>Specialists</th>
<th>Acute Hospitals</th>
<th>Hospital Outpatient services</th>
<th>Dentists</th>
<th>Pharmacies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation, fee-for-service, fixed budgets, co-payments</td>
<td>Fee-for-service, case payments, payment for quality, fixed budgets</td>
<td>Fee-for-service, case payments, payment for quality, fixed budgets</td>
<td>Fee-for-service, case payments, payment for quality, fixed budgets</td>
<td>Fee-for-service</td>
<td></td>
</tr>
</tbody>
</table>

What resources are available for the health system?

HEALTH PROFESSIONALS

The numbers of practising doctors (497 per 100 000 inhabitants) and nurses (1 788 per 100 000) in Norway are among the highest in Europe and, in the case of nurses, the number is more than twice the EU average (793 per 100 000) (Fig. 5a and b). The ratio of nurses to doctors (3.6) is also considerably higher than in most European countries. Yet, shortages of nurses are predicted in the next decades and there are already shortages of GPs in the primary health care sector and of nurses in the long-term care sector.

Nearly 40% of physicians in 2015 were foreign-trained; half of those were Norwegian-born but educated outside Norway. A new system of competency training was introduced in March 2017 to align education with changing population needs and these efforts are being continued under the Health and Hospital Plan 2020–2023.
FIG 5A  NUMBER OF PHYSICIANS PER 100 000 POPULATION IN NORWAY AND SELECTED COUNTRIES, 2002–2019


FIG. 5B  NUMBER OF NURSES PER 100 000 POPULATION IN NORWAY AND SELECTED COUNTRIES, 2002–2019


HEALTH INFRASTRUCTURE

There are 20 hospital trusts in Norway. The number of hospital beds has been declining over the years and reflects the government’s efforts to improve resource allocation by shifting inpatients to outpatient settings in the community and to day surgery. In 2019 there were 311 acute beds per 100 000 inhabitants in Norway, which is higher than in the other Scandinavian countries (Fig. 6). Public beds account for 96% of all hospital beds. The average bed occupancy rate is over 80%, above the OECD average of 75.7%, suggesting that spare capacity in the inpatient sector is fairly limited. Access to imaging diagnostic equipment is good, especially for magnetic resonance imaging (MRI) exams where it is among the highest in Europe (Fig. 7).
The use of e-tools has increased in recent years. In 2017, 96% of municipalities sent electronic referrals to hospitals and nearly all patient information sent from hospitals to municipalities was sent electronically. By the end of 2018 more than 92% of all prescriptions were e-prescriptions. Telemedicine is used to improve access to care and to provide continuous education to health personnel in remote areas.

In late 2020, a single portal for health data was created to improve access to existing health data for health care improvement, monitoring, management and research purposes. Its implementation is ongoing and has been challenging. Continued digitalization of the health system is also an essential aspect of the National Health and Hospital Plan for 2020–2023. The newly established National Data Service supports the Health, Demography and Quality of Life programme of the Nordic councils of Ministers, whose action areas include finding solutions on how to bridge Nordic health data and personal data for utilization in the Nordic health ecosystems. Moreover, an emergency preparedness register for COVID-19 (Beredt C19) integrates existing information from the health care service and several quality and administrative registries to provide a rapid overview and knowledge of how the pandemic and implemented measures affect the population’s health, use of health care services and health-related behaviour.

**FIG. 7** MAGNETIC RESONANCE IMAGING (MRI) AND COMPUTED TOMOGRAPHY (CT) EXAMS PER 1 000 POPULATION, 2019


<table>
<thead>
<tr>
<th>MRI exams</th>
<th>CT scans</th>
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<tr>
<td>Norway</td>
<td>120</td>
</tr>
<tr>
<td>Lowest and highest in EU (range)</td>
<td>6 (Cyprus) to 148 (Australia)</td>
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DISTRIBUTION OF HEALTH RESOURCES

The size of hospital trusts varies, from about 160 beds in the smallest trust (Sunnaas) to more than 1,600 beds in the largest trust (Oslo University Hospital). A single trust can cover vast geographical areas. For example, in the county of Nordland, the distance between hospitals within a trust can exceed 500 kilometres.

There are regional variations in access to GPs, with patients living in rural and smaller municipalities having poorer access. In nine municipalities, six of them in Northern Norway, there were no GPs at the end of 2018. In three counties, Finnmark, Nordland and Møre & Romsdal, vacant GP positions have left 2–4% of their populations without a GP, and the vacancies have been not filled for a long time.

How are health services delivered?

PRIMARY AND AMBULATORY CARE

Primary care is provided at the municipal level, mostly by self-employed physicians and as part of municipal services – in nursing homes and as part of home-based services (see Box 3). Team-based delivery of primary care is being piloted (2018–2023) alongside new primary care financing models. GPs act as gatekeepers, referring patients to more complex care.

The care coordination reform of 2012 put more emphasis on municipalities’ responsibilities for 24-hour care and services after hospital discharge, including obligating municipalities to establish individual treatment plans for patients with chronic diseases. In 2017 the Directorate of Health published national guidelines to support municipalities in developing comprehensive patient pathways for patients with multi-morbidities with high levels of care needs. Since 2019 cooperation between the municipalities and specialist care has been strengthened with the introduction of Healthcare Communities (see Organization).

BOX 3 | WHAT ARE THE KEY STRENGTHS AND WEAKNESSES OF PRIMARY CARE?

Primary health care has long been high on the policy agenda, with the coordination reform of 2012 setting a strategic vision for the health care system as a whole. In terms of access, 33% of patients see their GP on the same day (40% of patients within the next 4 days, and waiting times for non-emergency care appearing to be stable), and with more than 50% reporting easy access to out-of-hours care. Nevertheless, there may be some gaps in access due to lack of GPs in some areas, as well as the existence of user fees. The ongoing primary care reform is aimed, among other things, at improving the accessibility of primary care. The responsibilities of the municipalities will be extended to include more preventive health services, and primary health professionals other than medical doctors will be given the right to oversee follow-up care for chronic patients.
**HOSPITAL CARE**

Inpatient care is mainly provided by hospital trusts owned by the Regional Health Authorities. Hospitals also provide outpatient specialist care in their outpatient departments. Policy efforts since the 1980s have sought to replace relatively expensive inpatient care with less costly outpatient and day surgery and to bring care closer to patients’ homes. A range of treatments are now provided as day care, including somatic and psychiatric care and treatment of drug and alcohol addiction. Another strong focus has been the improvement of integrated care (Box 4).

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**BOX 4 | ARE EFFORTS TO IMPROVE INTEGRATION OF CARE WORKING?**

The Practice Consultant Scheme (Praksiskonsulent, PKO) has been in place since 1995 to help plan patient pathways and improve cooperation between primary care and specialized services. Within this scheme, GPs work part time (10–20%) in hospitals. However, the scheme faces challenges, given the limited time GPs can spend in hospitals due to increasing care responsibilities within municipalities. In some areas, especially for geriatric care and cancer treatment, specialist multidisciplinary mobile teams have been established by the hospitals. They provide guidance and care to patients at home or in other settings within the community.

Standardized patient pathways are implemented in municipalities and hospitals in Norway to ensure good coordination of evidence-based care. The Regional Health Authorities distinguish between three categories of patient pathways comprising hospital-based services, municipal health care services, and specialized health care services provided outside hospitals: (1) internal hospital pathways where patients stay and receive treatment and follow-up within the same hospital; (2) pathways involving several hospitals within the same hospital trust; (3) pathways involving different trusts in the Regional Health Authorities. Standardized cancer pathways have existed since 2015. In 2017 the Directorate of Health published national guidelines to support municipalities in developing comprehensive patient pathways for patients with multi-morbidities with high levels of care needs.

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**PHARMACEUTICAL CARE**

Access to pharmaceuticals, including innovative therapies, is comparatively good in Norway. Patient co-payments for outpatient pharmaceuticals are capped and certain population groups are exempt from cost-sharing. Prescription pharmaceuticals account for over 90% of pharmaceutical consumption and generics make up over 55% of total pharmaceutical sales. Norwegian doctors are among those prescribing the fewest broad spectrum antibiotics within the WHO European Region in an attempt to reduce the emergence of antibiotic-resistant bacteria.

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**LONG-TERM CARE**

Around 30% of spending on health in Norway is devoted to long-term care. Long-term care is provided in three types of setting: patients’ homes, nursing homes or sheltered homes run by municipalities. In nursing homes, there has been a deliberate shift towards increasing the number of single-occupancy rooms to make it more home-like. Palliative care services are provided at all levels of care, but the availability of palliative care does not always meet the demand. In the area of mental health care there has been a long-term shift towards de-institutionalization, and, more recently, an increase in financing for such services.
DENTAL CARE

Dental care for the adult population (20 years and older) is the area of care with the highest private participation, both in terms of provision and financing. Most dentists work in private practices (around 70% of all dentists) and most treatments are usually paid OOP in full by the patient. Fees charged in the private sector are not regulated.

What reforms are being pursued?

Key policy initiatives in recent years have included improving the coordination of care between municipalities and hospitals (the Coordination Reform); strengthening primary care and public health; extending patient choice; reorganizing hospital care; and adapting education and training of health professionals to future health needs (Box 5).

Evaluation of the Coordination Reform has shown mixed results so far. However, overall, it was found to have supported delivery of care at the lowest, effective level of care and it paved the way for the primary care and public health reforms of 2015. Primary care teams are being piloted in 2018–2023 with the goal of instituting multidisciplinary environments.

Related to this, and in line with the Health and Hospital Plan 2020–2023, a new action plan sets out plans for adapting competencies of health professionals to future health needs. Ongoing reform efforts focus on the following areas: public health (focus on children and youth and prevention of loneliness); primary care (evaluation of the regular GP scheme); substance abuse (more emphasis on prevention and harm reduction); and long-term care (creating an age-friendly society). Digitalization is also high on the policy agenda for 2020–2023, with a single health portal created in 2019 (see Health infrastructure).

BOX 5 | KEY HEALTH SYSTEM REFORMS OVER THE LAST 10 YEARS

- **Coordination Reform** (2012): to improve coordination of care between municipalities and hospitals, and to strengthen public health (implemented)
- **Strategy on Quality and Patient Safety** (2013): to provide a comprehensive approach to quality and patient safety (under implementation)
- **Choice Reform** (2014): to extend patient choice of treatments and providers (implemented)
- **National Health and Hospital Plan 2016–2019 (2015) and 2020–2023**: empowerment of patients; prioritizing mental health services and treatment of substance abuse; improving provision of health care; ensuring the right volume and skill-mix of human resources; improving quality and patient safety; improving coordination between hospitals and strengthening outpatient care (under implementation)
- **Primary Care and Public Health Reform** (2015): introduction of team-based intermediate care (under implementation)
- **Competence Shift 2020** (2015): to adapt education and training in primary care to future health needs (under implementation)
- ‘**Live your whole life**’ reform (2017): to improve quality of care for older people (under implementation)
- **Drug Reform** (2018): to transfer responsibility over minor drug offences from the Ministry of Justice to the Ministry of Health and Care Services (i.e. shifting focus from punishment to treatment) (under implementation)
- **Implementation of Healthcare Communities** (since 2019): to formalize governance structures between the municipalities and specialist care to improve joint planning of services and strengthen care coordination.
How is the health system performing?

HEALTH SYSTEM PERFORMANCE MONITORING AND INFORMATION SYSTEMS

Transparency in the health care system has been a political priority over the past few decades. Public monitoring of performance indicators in policy processes has improved and has been used more widely over the past three decades. Public reporting on hospital resources started in 1989 and became systematic a decade later, while reporting on patient experiences and mortality after hospitalization started in 1997. A new database with comparative data on health and social care services at the municipality level (KOSTRA) was established in 2018. Municipalities, health trusts and state agencies all provide data to Statistics Norway.

The Directorate of Health is responsible for the development, maintenance and dissemination of the results from the National Quality Indicator System (NQIS), which was introduced in 2014. The system serves several purposes: to support health care users and their next of kin in making informed choices about health care providers; to inform the public about the quality of health care services; and to generate data to support management and quality improvement in health care. The Directorate of Health also publishes annual SAMDATA reports – a collection of comparative statistics and performance indicators for hospital trusts containing information on specialist care, including mental health care (since 2017 also at municipality level).

ACCESSIBILITY AND FINANCIAL PROTECTION

Access to health care for all who need it is considered to be a basic social right in Norway, and ensuring universal and equitable access to health care is an important health policy aim embedded in the Patients’ Rights Act of 1999 and its later amendments. The distribution of hospitals in Norway reflects the distribution of 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. Despite the high density of health care personnel, Norway still struggles to ensure equal access to health care across its entire territory, particularly in rural and sparsely populated areas.

The Norwegian health system offers a high level of social and financial protection. Population coverage is universal and public financing accounts for the vast majority (85%) of health expenditure. Various mechanisms, such as exemptions and ceilings on OOP payments, limit the financial burden of care on individuals. However, the level of protection is poor for certain types of care, such as home-based services and institutional care for older or disabled people and adult dental care. Nevertheless, unmet need for medical examination is relatively small in Norway – 0.9% of the population in 2020 (Fig. 8). In 2019 only 0.2% of the population reported unmet need specifically due to cost.
HEALTH CARE QUALITY

Norway has conducted several patient experience surveys (Box 6). High levels of hospital admissions for certain conditions, such as asthma, chronic obstructive pulmonary disease, congestive heart failure (CHF), hypertension and diabetes, may indicate inefficiencies and/or weaknesses in primary care. In 2019 in Norway the rate of avoidable hospital admissions from those
diseases combined was higher than in the Netherlands or Sweden, but lower than in several other countries for which data are available such as Denmark, Finland, France and Germany (Fig. 9).
In terms of effectiveness of specialist care, Norway has among the best outcomes in terms of mortality from acute myocardial infarction (AMI) and stroke within 30 days of hospitalization in Europe. Despite already low mortality rates, further improvements have been achieved in recent years, with the mortality for AMI decreasing from 3.7 per 100 patients in 2017 to 3.2 in 2019 and for ischemic stroke from 4.5 to 3.8. During this time a patient care pathway for stroke has been developed, alongside initiatives to raise awareness around early symptoms and signs of stroke among the population. The survival gains seen for stroke are mainly attributable to 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.

**Notes:** COPD: chronic obstructive pulmonary disease.

Data for congestive heart failure and diabetes not available in Latvia and Luxembourg.

**Source:** OECD Health Statistics, 2021 (data refer to 2019 or nearest year).
HEALTH SYSTEM OUTCOMES

The health status of the Norwegian population is very good by international standards and has improved considerably over the last decades. Mortality amenable to medical intervention, defined as “premature deaths from causes that should not occur in the presence of timely and effective health care”, is used as an indication of the contribution that health care makes to improve population health. Preventable mortality is 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).

Fig. 10 shows amenable and preventable deaths in Norway and across the EU/EEA in 2000 and 2019, although available data for Norway are for 2016. In terms of both amenable and preventable mortality, Norway ranks among the countries with the lowest rates in Europe. Between 2000 and 2016 amenable mortality in Norway has almost halved, from 117 to 60 deaths per 100 000 inhabitants. Over the same period preventable mortality decreased from 50 to 35 deaths per 100 000. Part of Norway’s low levels of amenable mortality may be attributed to a large reduction in mortality from ischemic heart disease and increased rates of survival from some of the treatable cancers. The overall positive trend in survival of treatable cancers reflects both screening and improved diagnostics, as well as improved treatment.

BOX 7 | ARE PUBLIC HEALTH INTERVENTIONS MAKING A DIFFERENCE?

For more than 50 years Norway has implemented targeted anti-tobacco interventions. They include high taxes on tobacco, warnings on all tobacco packaging and restrictions on smoking in public, with smoking restricted in public areas since 1988 and prohibited in all indoor public areas since 2004. These interventions have led to decreasing rates of tobacco smoking. However, the use of snus (tobacco snuff) has become increasingly common over the past two decades. The most recent regulations on tobacco products, which came into effect on 1 July 2017, require standardized packaging of cigarettes, roll-your-own tobacco and snus. They also extended the existing smoking restrictions to the use of e-cigarettes.

In 2015 the government launched the National Strategy against Antibiotic Resistance for 2015–2020. The goal was to reduce the use of antibiotics in humans by 30% by 2020. In the period 2012–2015 the use of antibiotics in inpatient care decreased by 13%. Use of antibiotics in animals in Norway is among the lowest in Europe and is partly explained by the use of vaccines in aquaculture – since 1987 antibiotic use in aquaculture, measured as total weight, has decreased by 99%.

The five-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.
FIG. 10  AMENABLE AND PREVENTABLE MORTALITY PER 100 000 POPULATION IN NORWAY AND OTHER EEA COUNTRIES, 2000 AND 2019

Notes: EEA: European Economic Area.
Age-standardized death rates for all persons calculated by European Observatory for Health Systems and Policies.
Source: Mortality and population data from WHO detailed mortality files (released June 2021); amenable causes as per list by Nolte and McKee (2004); preventable causes: lung cancer, chronic liver disease, road traffic.
HEALTH SYSTEM EFFICIENCY

A number of different 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 takes into account population needs including the number of inhabitants living in the region, as well as their age and income, and the levels of service use (in the case of allocation to the Regional Health Authorities).

Norway is among the top spenders on health measured in terms of spending per capita, while the share of GDP spent on health is closer to the OECD average. There has been a continuing debate whether this level of spending is not excessive. As a result, a special report from the OECD Health Division was 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. The report concluded that high spending in Norway is in line with the country’s wealth and demographic structure. As in many European countries, inpatient care in Norway saw a shift towards outpatient settings, leading to a decreasing number of hospital beds, shorter length of stay and wider use of day surgery. Nevertheless, there are more curative hospital beds in Norway than in Sweden, Denmark or Finland (Fig. 6).

Another area for potential efficiency gains is pharmaceuticals (Box 8). In 2021 generics constituted just over 55% of the pharmaceutical market, which is similar to the EU average, but below the share in Denmark (60%), for example. In late 2018 Norway and Denmark established a joint initiative to further promote the use of generics and increase the market share of biosimilars.

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 National Insurance Scheme. The generics share of the pharmaceutical market rose steeply until 2008 and then stabilized between 2009 and 2014. 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 1 000 population per day in 2020. Norway has also been at the forefront of increasing biosimilars uptake, via for instance 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 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 prevention measures and treatment. Norway also has a well-developed system of long-term care compared with other countries in Europe. Long-term care receives close to a third of the total public spending on health. There are efforts to make the health system more age-friendly and address mental health problems. Norway also works on further strengthening primary and hospital care, improving coordination between various types of care, and adapting medical education to future health needs.
### POPULATION HEALTH CONTEXT

#### KEY MORTALITY AND HEALTH INDICATORS

<table>
<thead>
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<th>LIFE EXPECTANCY (YEARS)</th>
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<tbody>
<tr>
<td>Life expectancy at birth, total</td>
<td>83.3</td>
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<tr>
<td>Life expectancy at birth, male</td>
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<tr>
<td>Life expectancy at birth, female</td>
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<table>
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<th>MORTALITY (SDR PER 100 000 POPULATION)</th>
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<tr>
<td>All causes*</td>
<td>871</td>
</tr>
<tr>
<td>Circulatory diseases*</td>
<td>220</td>
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<tr>
<td>Malignant neoplasms*</td>
<td>235</td>
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<td>Communicable diseases*</td>
<td>20</td>
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<tr>
<td>External causes*</td>
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<tr>
<td>Infant mortality rate (per 1 000 live births)</td>
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<tr>
<td>Maternal mortality rate per 100 000 live births (modelled estimate)</td>
<td>2</td>
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</tbody>
</table>

**Notes:**
- SDR: standardized death rate.
- Age-adjusted rates with the European standard population 2010.
- **Source:** Eurostat, 2022; World Bank, 2022 for maternal mortality.

### REFERENCES

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).