

Norway and Health

an introduction



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Contact: Secretariat for International Cooperation
Postal address: Pb. 7000 St Olavs plass, 0130 Oslo
Visiting address: Universitetsgata 2, Oslo

Tel: 810 20 050

Fax: 24 16 30 01

www.helsedirektoratet.no

This booklet may be ordered at:
Norwegian Directorate of Health
att. "Trykksaksekspedisjonen"
e-mail: trykksak@helsedir.no

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Please send your comments to: f-arkivar@helsedir.no,
att. "Secretariat for International Cooperation".

Editorial Team: Sigurd Røed Dahl
Lal Manavado
Øydis Monsen
Harald Siem

Subject contributors: Bente Hatling, Hospital Services
Bente Moe, Community Health Services
Bente Nystad, Care and Dental Health Services
Freja U. Kärki, Mental Health
Gabrielle Katrine Welle-Strand, Substance Abuse
Heidi Tomten, Physical Activity
Kaja Lund-Iversen, Nutrition
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Michael Kaurin, Health Statistics
Øyvind Christensen, Norwegian Patient Register Department
Ragnar Salmén, Emergency Preparedness
Rifa Lill Lindbak, Tobacco
Tone P. Torgersen, Environmental Health
Toril Laberg, Delta Centre

Preface

There has been a growing interest abroad in the Norwegian health and care services. This booklet outlines the structure and some key factors that shaped the system into what it is today.

It is firmly anchored in the Norwegian traditional political tenet that society is collectively responsible for the welfare of its citizens. Thus, an overarching aim is to provide services of high quality, available within acceptable waiting times and distances, reaching out to everyone regardless of their financial situation, social status, age, gender and ethnic background.

During the last four decades, Norway has undergone a substantial socio-economic transformation, and is now among the wealthiest nations in the world. This development has been of great significance to the health status of the nation, the services provided and the public expectations of the health services.

A national health system is the result of a dynamic interplay between health needs, public expectations, professions, interest groups and available resources. As all these elements change over time, the system is in constant evolution.

To be adequate, a health system in evolution has to contain mechanisms for priority and capacity revision, quality assurance, structural adjustment, and optimal resource utilisation. One major concern in Norway as an egalitarian society is the growing disparity in health between social groups, in spite of universal access to care and services. A comprehensive policy on social determinants of health is developed in order to reduce social inequalities in health.

The principal elements of the structure and activities are outlined here, with a slight bias to the work under the responsibility of the Norwegian Directorate of Health. There have been many contributors, which is apparent in the variation in writing style of the chapters. A special note of gratitude goes to Lal Manavado, who initiated this project and contributed extensively throughout the process. We hope this booklet will give you a quick overview that you will find interesting, informative and useful as a first introduction to health in Norway.



Bjørn-Inge Larsen
Director General

Bjørn-Inge Larsen, (MD, BC, MBA, MPH), is a member (and chair 2009) of WHO Standing Committee of the Regional Committee for Europe for the period 2006-2009.

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1 International cooperation on health

Norway is an active participant in the international efforts to enhance global public health. Over the years, Norway has seen the World Health Organization (WHO) as the central arena for international health. Karl Evang, former Director of health, was one of the founders of the organization in 1948, while former Prime Minister Gro Harlem Brundtland served as Director General from 1998 to 2003.

The Director of health, Bjørn-Inge Larsen, is a member (and chair 2009) of WHO Standing Committee of the Regional Committee for Europe for the period 2006-2009.

Prime Minister Jens Stoltenberg (2005-) has been actively involved in UN-reform and the intensified campaign to meet the Millennium Development Goals four and five by 2015. Minister of Foreign Affairs, Jonas Gahr Støre, has in collaboration with six other Ministers of Foreign Affairs initiated a process of looking at health and diplomacy, to explore the areas where foreign affairs cover global health issues. This embraces threats like pandemics, trade issues like patent rights and the cost of essential treatment in poor countries, as well as responsible recruitment of health personnel. Last but not least, reconstruction of failed states and humanitarian assistance in emergencies shall also be added to these issues.

Mention must also be made of regional health cooperation. Collaboration with the Nordic and Baltic States, as well as Russia, is given high priority. The latter in particular has seen a dramatic upturn since the early nineties. Many health projects and programs related to tuberculosis control, prevention of HIV-infections, child health care and prevention of lifestyle-related disease, have been carried out.

The EU plays a significant role in European health cooperation, and although not an EU-member, Norway is involved in a variety of EU activities. A large number of EU directives are implemented in Norway. This is particularly true in the field of food safety. Other areas of cooperation include health preparedness, cross-border patient mobility and participation in EU-programmes. Norway also participates in four health-related EU-agencies: European Medicines Agency (EMA), European Centre for Disease Prevention and Control (ECDC), European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the European Food Safety Authority (EFSA).

2 Norway, the nation

Norway is a founding member of the United Nations, NATO and the Council of Europe, but is not a member of the European Union (EU). Norwegian voters turned down EU membership by narrow margins in 1972 and 1994. However, Norway is part of the EU internal market, and has an extensive cooperation on most policy areas through the European Economic Area (EEA) agreement.

2.1 Geography

Norway is located in Northern Europe, bordering the North Sea and the North Atlantic Ocean. Half the country lies north of the Polar Circle. It borders Sweden, Finland and the Russian Federation.

The country is divided into 19 regional authority areas, counties (fylker), which in turn are divided into more than 430 local authority areas, municipalities (kommuner). The capital is Oslo. The Norwegian climate is temperate and wet along the coast, modified by the North Atlantic Current. The inland climate is dry, and cold in winter. The terrain is mostly high plateaus and mountains broken by fertile valleys. The coastline is deeply indented by fjords. About two-thirds of the country consists of mountains, and there are some 50,000 islands along the coastline.

Norway has rich resources of petroleum, natural gas, hydropower, fish, timber, and minerals like iron, copper, lead, zinc, titanium, pyrites and nickel. As for land use, only 3 percent of the land is arable, while 27 percent of the land is forests and woodlands.

Figure 1 Neighbours and communications



Map by Egil Sire

2.2 Demography (2007)

Norway has a population of 4,799,300 (01.01.2009).

Life expectancy at birth

Year	Male	Female
1970	71	77
2007	78,2	82,7

Age Structure	Percent
0-14 years	19
15-64 years	66
65 years and over	15

Population growth rate: 0,38 percent

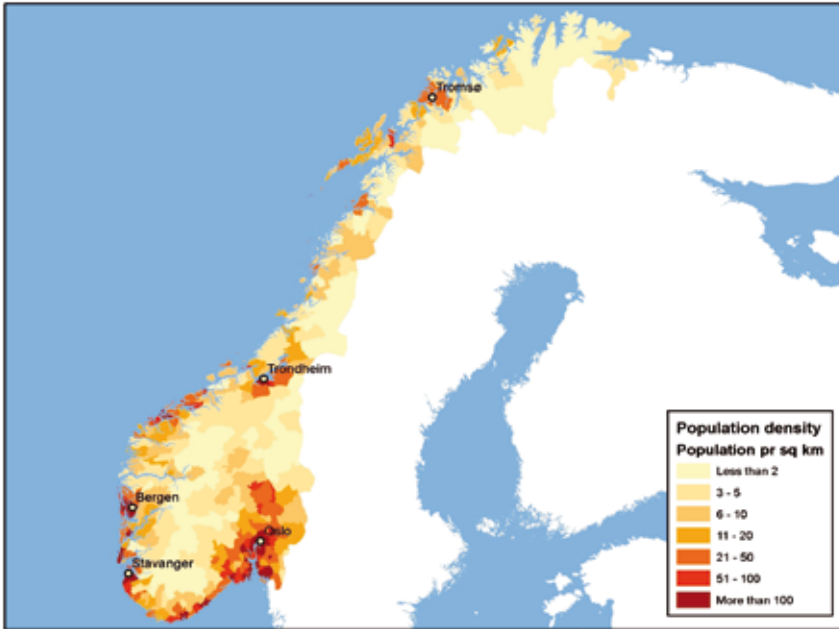
Birth rate: 11,5 births/1,000 population

Death rate: 9,4 deaths/1,000 population

Infant mortality rate: 3,7 deaths/1,000 live births

Total fertility rate: 1,78

Figure 2 Demographic map



Map by Egil Sire

2.3 Government

Norway, officially the Kingdom of Norway, is a constitutional monarchy with a parliamentary system of government. Norway adopted its constitution in 1814, and the King was given executive powers. Today, these are effectively exercised by the government, headed by the Prime Minister. In 1898, all men were granted universal suffrage, followed by all women in 1913. In terms of government, the social democratic Labour party has played a predominant role after the Second World War.

The counties, or the provincial councils and the local authorities, have a great deal of political autonomy. They also set their own tax range within limits prescribed by the Parliament. Representatives to the provincial and local councils are elected every four years by proportional representation. A representative usually from the largest political party or coalition is chosen as the chair of the council, and he or she is also the Mayor of the local authority area.

2.4 Economy

The Norwegian economy may be described as welfare capitalism, featuring a combination of free market economy and government interventions and regulations. The government controls key areas, such as the petroleum sector. International oil prices are important as oil and gas account for a third of the exports. Surpluses from the gas and oil exports are kept in a Government Pension Fund - Global, which is invested abroad. In 2007, the size of the fund was 373 USD billion. (Norwegian Ministry of Finance, 2007).

The Norwegian progressive tax system is based on indirect taxes such as value-added tax (VAT), personal income tax and corporate tax, including employers' social security contributions.

Food processing, shipbuilding, pulp and paper products, metals, chemicals, timber, mining, textiles, aquaculture and fishing are among the most important other industries. Barley, other grains, potatoes, beef, milk, and fish are among the principal agricultural products of the country.

2.5 Health

Selected data on the population's health:

In 2006, cancer and cardiovascular diseases accounted for over 60 per cent of deaths. Cancer is the primary cause of death for people under 70 years of age, while cardiovascular diseases, such as heart attack, are the primary killers for people 70 years and over. This trend is unchanged over the past decade.

Owing to the increasing life expectancy, the number of elderly has risen considerably. This has brought a high prevalence of dementia, cancer, heart and lung insufficiencies and musculoskeletal illness among the elderly.

As for infectious diseases, 250 to 350 cases of tuberculosis are diagnosed every year. Active tuberculosis among native Norwegians is rare, while immigration in recent years has led to an increase in the incidence of the disease.

In 2007, 248 new cases of HIV infection were reported, against 276 cases the previous year. The decline can be explained by a reduction in the number of asylum seekers and family unifications from high endemic countries, and a decrease in the number of men having sex with men (MSM) diagnosed with HIV the same year. However, from 2003, there has been a marked and disturbing increase in contamination among MSM, similar to the situation in other parts of Europe.

Each year, 400,000 to 450,000 accidents occur that require medical attention. About 53 000 of these require hospitalization. In 2006, accidents accounted for 1824 deaths.

As for drug and alcohol abuse, it is estimated that there are about 9,000 to 12,000 heroin addicts out of whom 4,500 are enrolled in medical (methadone) assisted rehabilitation programs in 2006.

The highest consumption of alcohol since 1870 was recorded in 2007 (6,6 litres of pure alcohol per inhabitant). However, statistics from 2008 shows a decrease in consumption among youth the last decade. In 2004, 35,000 cases of alcohol and diverse types of substance abuse required medical treatment. In 2006, 2,037 hospital admissions presented cirrhosis as their main or secondary complaint.

Compared to the beginning of the 1990s, the birth rate among teenagers for 2007 is reduced by half. In 1990, the birth rate among teenagers (15-19 years) was 17,1 per 1000 women, compared to 9,1 in 2007. In the same age group, about 65 percent of the pregnancies terminate in abortion. The age group 20-24 years has the highest rate of abortion. In 2007, there were 29,3 terminations per 1000 women.

Although the general level of health in Norway is high compared to other countries, there is still a marked social gradient in morbidity and mortality.

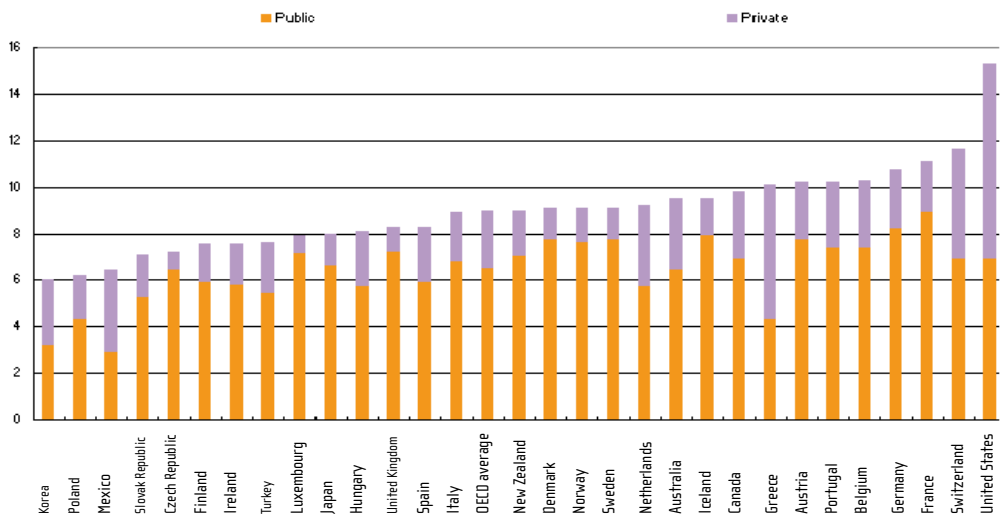
3 Health: Financial and human resources

In 2006, the Norwegian per capita total health expenditure of USD 4,520 (adjusted for purchasing power parity) ranked second among the OECD countries (OECD Health Data 2008). The period between 1997 and 2006 saw a variation in the health expenditure as GDP ratio ranging from 8,4 percent to 10 percent, peaking in 2003, decreasing to 8,7 percent in 2006.

In 2007, the total health expenditure, public and private, was 203 billion Norwegian kroner. Norway has one of the largest shares of public financing of health services per capita in the world. As the figure below shows, public expenditure on health as a percentage of GDP is currently 7,6 percent, whilst private expenditure amounts to 1,5 percent.

The largest part of public health expenditure is incurred by the curative care provided in hospitals. At the local level, more than 80 percent of public health expenditure is related to care services. In 2006, only 2,7 percent of the total health expenditure was spent on prevention (including administration).

Figure 3 Expenditure on health. As a percentage of GDP, OECD Factbook 2008: Economic, Environmental and Social Statistics, OECD 2008, www.sourceoecd.org/factbook.



3.1 Manpower

The health authorities have been active, both on the national and international arena, in order to seek a better balance between demand and supply of health care personnel. Important issues are capacity and skills mix on the domestic level, and fair treatment and understanding of the needs in poorer countries.

The demand for health personnel at home will be met in the short run with minor adjustments. In 2008, there were four thousand more health and care personnel with university degrees on the job market than ten years earlier. However, there will be a shortage of auxiliary nurses and dentists.

There has been an attempt to regulate the supply and distribution of physicians from the end of the 1980s. However, during the 1990s, this regulation was undermined by hospitals; many positions were occupied without official approval. At the same time problems with unoccupied positions in the municipalities increased, especially in rural areas. In 1999, the regulatory system for physicians was changed from a contract-based system to a statutory system. The National Council for Physicians Distribution and Specialist Structure was set up to advise the Ministry of Health and Care Services. The new regulatory regime came into effect in 1999.

3.2 Registration/licensing of personnel

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

www.safh.no

Following the European Economic Agreement (EEA), Norway adheres to the EU directive on the recognition of professional qualifications, also in the case of health care personnel. Furthermore, according to the Health Personnel Act, an applicant from a country outside the EEA may also be authorised if she or he has passed a foreign examination that is recognised as equivalent to the Norwegian requirement, or has otherwise been proven to possess the necessary skills.

At present, employment in 36 health professions requires prior authorisation. A peculiarity in Norway is the renewals upon application of doctor's licence to practice, which expires routinely at 75 years of age.

Table 1 Health professionals in Norway, by profession, 2006.

Profession	Number
Auxiliary nurses	108 200
Dieticians	258
Dental nurses	1 300
Dental technicians	700
Dentists	6 200
Dispensers	1 500
Doctors	30 300
Ergotherapists	3 400
Medlab technicians	6 200
Midwives	4 100
Nurses	122 700
Opticians	1 600
Other professional or paraprofessional	3 000
Pharmacists	3 400
Pharmacy technicians	4 500
Physiotherapists	11 700
Psychiatric nurses	10 800
Psychologists	5 400
X-ray technicians	2 900

4 Health management

The health administration can be divided into three parts; the national, provincial and local levels.

4.1 Health at the national level

The Ministry of Health and Care Services formulates and implements the national health policy with the help of several subordinate institutions.

www.hod.dep.no

The Norwegian Directorate of Health is a specialized agency under the Norwegian Ministry of Health and Care Services. As such, it is responsible for the compilation of various ordinances, national guidelines and campaigns. It also advises the ministries concerned on health policy and legislation.

Its administrative activities involve management of grants for service projects and research, the Norwegian Patient Register and the implementation of certain statutes, while it executes diverse projects designed to promote public health and improve the living conditions in general.

www.helsedirektoratet.no

The Norwegian Board of Health is an independent authority responsible for the general supervision of the health services of the country. It has a tiered structure, and its central office directs its regional units set up at the province level. The medical officer of a county, who is reporting to the provincial governor, directs the unit. The supervisory authorities are concerned with quality, legal aspects, complaints and the task of ensuring adequate and equitable health services.

www.helsetilsynet.no

The Norwegian Institute of Public Health (NIPH) is the main source of medical information and advice. The institute is responsible for six out of seven national health registries. The Cancer Registry is a separate administrative unit. The registries are used for research and surveillance purposes. NIPH bears the responsibility for ensuring good utilisation, high quality and easy access to the data in the registers, as well as assuring that health information is treated in accordance with privacy

protection rules.

The seven central health registers have been established in accordance with the Personal Health Data Filing System Act. They are:

1. The Cause of Death Register
2. The Cancer Registry of Norway
3. The Medical Birth Registry of Norway
4. The Norwegian Surveillance System for Communicable Diseases (MSIS)
5. The Tuberculosis Registry
6. The Childhood Vaccination Register (SYSVAK)
7. The Norwegian Prescription Database

www.fhi.no

The Cancer Registry of Norway is a governmental institute for population based cancer research. The Registry has recorded cancer cases nationwide since 1953. A computerized population registry combined with the matching of information from several sources has resulted in accurate and complete cancer registration. This information is used in research projects to establish new knowledge about cancer causes, progression, diagnosis and effect of treatment.

www.kreftregisteret.no

The Norwegian Medicines Agency is the administrative organ for drugs approval. It authorises and monitors the use and sale of pharmaceuticals, as well as the proper and economical use of them. It licenses the importers of pharmaceuticals and their local distributors.

The agency is also responsible for the classification of pharmaceuticals, the drug and doping list, standardisation, pharmaceutical post-marketing control, medical post-marketing control, monitoring adverse drug reactions, supervision of pricing, and the determination of the pharmaceuticals to be included in the national subsidy list.

www.legemiddelverket.no

The Norwegian Radiation Protection Authority (NRPA) is the technical authority on radiation and nuclear safety, on which it is consulted by various home authorities. It administers statutes concerned with radiation and nuclear safety, and supervises

the medical, industrial and research activities that involve the emission of radiation.

NRPA monitors the natural and man-made radiation in the work place and in the environment, and also manages the national nuclear emergency preparedness plan.

www.nrpa.no

Several Norwegian public institutions collect information for statistical purposes, but Statistics Norway (SSB) is the central body responsible for collecting, analysing and disseminating official statistics, including statistics on health. According to the Statistics Act of 1989, Statistics Norway has the authority to decide what should be official statistics and is responsible for organising all official statistics in Norway.

www.ssb.no/english

The Norwegian Patient Registry (NPR) is part of the Norwegian Directorate of Health, and is responsible for providing data for planning, evaluation and financing for publicly funded specialized health care. The NPR covers nearly all in-patient and out-patient hospital care. The registry covers mental health and somatic care, and includes activity and waiting lists. Data on specialized treatment for substance abuse and additional data on accidents is also provided. Data on the patient's age, sex and residence, hospital and department, diagnose(s), medical and surgical procedure(s), dates of admission and discharge as well as date of procedure are included in the registry. The unique personal identification number that each citizen possesses is to date not included. However, the Parliament has decided that an encrypted version of the unique personal identification number can be added from March 2007 and onwards.

The NPR has data covering 629 specialists who work as private practitioners in the somatic sector, performing 1 772 610 consultations, which amounts to about 35 percent of all publicly financed out-patient consultations in 2007 for somatic illness.

Data from the somatic sector for the first quarter of 2008 contain information about 300 000 hospital stays, 191 000 day care episodes and 1 376 000 out-patient episodes. As regards the mental health sector, there are similar data available for

adult in- and out-patient clinics and adolescent in- and out-patient clinics, respectively.

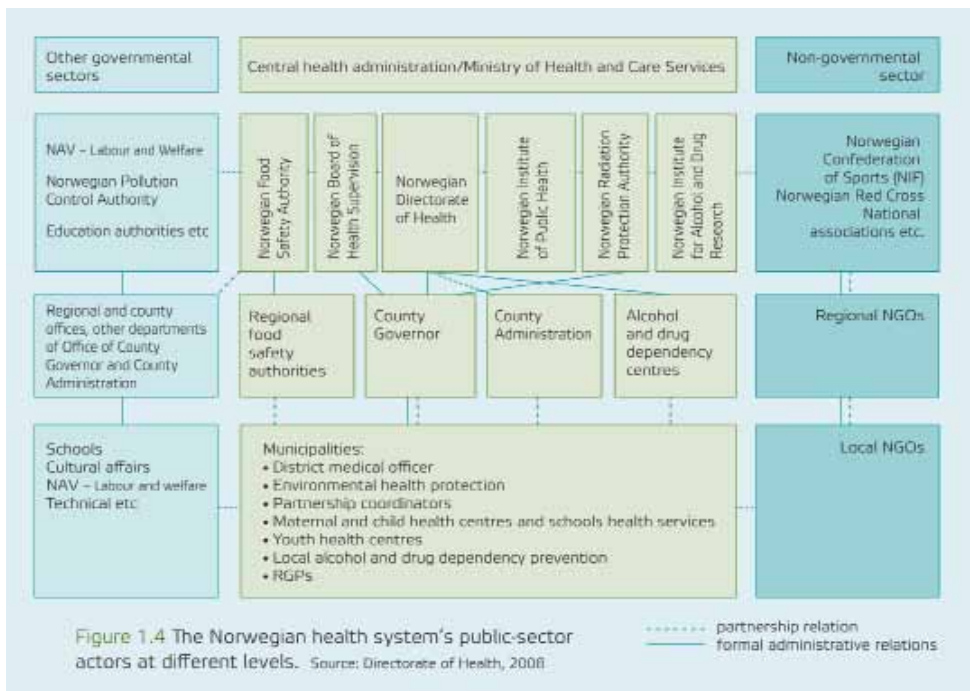
4.2 Health at the provincial level

The provincial authorities represented by the county council do not deal with health matters. Specialist services are organized in “health enterprises”, see below.

The chief state representative of a province is the governor, who is appointed by the central government. He or she is assisted by an executive board of civil servants, including the County Medical Officer and the Dental Surgeon of the province.

4.3 Health at the local level

Local authorities, the municipalities, through its council and administration represent the ground level of the administrative hierarchy. It is entrusted with the provision of a wide variety of primary health services.



5 Primary health services

The primary health services in the present form were established through The Norwegian Primary Health Services Act of 1982. The responsibility for the primary health services was given to the 430 local authorities. According to the act, the municipalities are to provide for care and treatment of all persons within its boundaries, including health promotion and prevention, emergency care and immigrant health care.

5.1 Scope

The services include general practice, pregnancy and antenatal care, health clinics for mother and child, school clinics, mental health care, nursing homes, rehabilitation, physiotherapy, communicable disease control, preventive medicine, environmental health and health promotion. They are assigned components of the national emergency preparedness plan, and provide for prisoners, refugees and asylum seekers located in the area.

5.2 Roles

The municipal council plans and implements these services through a director of primary health services. A municipal medical officer is appointed to advise the local council on health issues. In scarcely populated areas, some municipalities jointly establish and run all or a part of their primary health services.

The municipal medical officer is concerned with public health in the municipality. He provides information on available services, prevention of diseases, health promotion and organization of services. He also works to ensure that the building and operation of industrial installations, commercial and other activities pose no threat to public health. In serious cases, activities may be stopped.

Health personnel are either contracted to provide services, or employed by the municipality. The former is true for most of the general practitioners (GPs), while nurses and midwives usually are employees.

5.3 Financing

Primary health services are financed through grants from the national government, local tax revenues, reimbursements from the National Social Security

System and through out-of-pocket payments. Services of the pre- and antenatal clinics, youth clinics, school clinics, and all consultations for children under 12 years of age are free.

5.4 The general practitioners' scheme

In 2002, the national authorities introduced a regular general practitioners' scheme, giving individuals the right to choose one general practitioner as family doctor. In 2008, about 3,800 physicians are enlisted in this scheme.

They are private practitioners who enter into a contractual agreement with the municipality, and are required to have a regular clientele not exceeding 2,500 persons. In addition to consultation fees, they receive a regular monthly capitation allowance for each person on the list from the municipality. It is part of the agreement that they also serve in health clinics, school clinics, local authority nursing homes, prison health service and emergency units on a part-time salaried basis.

Patients may choose a practitioner anywhere, also in another municipality. If dissatisfied, they may change their physician up to two times within a calendar year.

5.5 The health clinics

The health clinics comprise four units. Pregnancy clinics and clinics for mother and child provide antenatal services and child health services that extend up to pre-school age. A public health nurse runs the clinics with a physician at hand for consultation when indicated. Midwives, physiotherapists, psychologists and other professionals may also be engaged at these clinics. The services provided include assessments, follow-ups, referrals, vaccinations, counselling, home visits and provision of information and cooperation with other social services for more comprehensive service packages.

Youth clinics provide integrated individual prevention services, covering physical and mental health assessment and advice, nutrition, physical fitness, sexual hygiene, problems of adolescence, contraception, family problems, and rehabilitation of the disabled and the chronically ill.

School health services serve school children and youth under 20 years of age. The school clinics provide vaccinations, health promotion and social and psychological support in the school environment.

The clinics for school children are usually located at schools, while the youth clinics are strategically located elsewhere in the municipality. They have flexible hours of consultation.

5.6 Health and care services for the elderly and disabled

The most important services include health and medical services, nursing homes, home based care and services, assistance at home and community nursing, relief services for family members and day care and activity centres. There has been a shift away from institutional care in favour of community-based care. Most importantly, this concerns community-based care for the mentally ill and disabled, and functional homes for the physically disabled to facilitate living at home.

5.6.1 Users

The services have more than 200,000 users, of which 40,000 live in nursing homes, and more than 160,000 people receive home care services in community care housing or their own home. The number of users aged under 67 has doubled over ten years and totals 50,000. In 2005, around 110,000 man-labour years were employed; half in nursing homes and half in home care services and community care.

5.6.2 Personnel

The growing population of the elderly demands new ways of thinking and training of new skills. Towards year 2020 efforts will be intensified to train personnel and invest in appropriate buildings and technology. Special attention is given to patients with dementia. At present, about 66,000 people suffer from this condition, a number that will probably double during the next 35 years.

5.7 Public dental health services

The Public Dental Health Services (PDHS) were established in 1950. Local government is responsible for planning and funding of the service. All children aged 0-18 years receive free treatment, except for orthodontic care, for which parents have to pay a partial fee according to the degree of malocclusion .

5.7.1 Frequency of use

About 75 percent of adults use the services every year, and 85 percent visit at least every second year. Since 1996, there have been no set fees in the private sector. A private dental insurance scheme was introduced in 1996 without success. A few companies offer subsidised dental treatment to their employees.

In 2006, for a population of 4,6 million there were 1000 full time dentists in the public sector compared to 2700 private sector dentists. There were 339 full time dental hygienists in PDHS and 261 in the private sector.

5.7.2 Costs

In 2007, the total cost of dental treatment in PDHS and the private sector combined was EUR 1,285 million. The total cost included EUR 175 million spent in the PDHS, and a further EUR 122 million refund from the State Insurance System to adults for dental treatment as well as orthodontic treatment for children. Out-of-pocket spending on dental care for adults was thus about EUR 1 billion.

The oral health of the adult population is considered to be good. In 2006, the national mean DMFT score, number of fillings, in 12 year-olds was 1,6 and 44 percent had no visible caries.

6 Specialist health care services

Specialist health care services include hospitals for patients with somatic or psychiatric/psychological disorders, out-patients departments, centers for training and rehabilitation, institutions for drug addicts, centres for re-education for chronically ill patients and disabled, pre-hospital services and private specialists, laboratories and x-ray facilities.

The Norwegian specialist system scores high in international comparison. In a WHO-study from 2004, Norway was ranked third. If asked, four out of five state that they are satisfied with services received.

Figure 4 The four health regions



Map by Egil Sire

6.1 Health enterprises

Major reforms in the specialised health care services were instituted by The Regional Health Authorities Act of 2002. Five regional health enterprises (later reduced to four through a merger) were set up to administer services within each region, with appointed boards responsible for governance and results.

Following the reform, responsibility for all the public hospitals, polyclinics and the district psychiatric centres in the country was transferred to the state, and a system of enterprise ownership and management was established.

The services include all hospital services, ambulance services, emergency call system, laboratories, in-house pharmacies and some medical rehabilitation facilities.

Each regional health enterprise directs a set of subordinate units, mostly hospitals, known as health enterprises. In 2007, about 84 public hospitals were part of this system. Private specialist health service facilities may be invited as partners to the system on a contractual basis.

Each enterprise is directed by a board of management serving a two-year term. The boards are supposed to run the enterprises like businesses, in particular guaranteeing solvency. Towards the end of the decade, however, there has been great concern regarding the uptake of massive loans by the enterprises.

6.2 Allocations

The Norwegian health system is, as mentioned, a tax-based system covering all inhabitants.

In consultation with the health authorities, the government makes annual budget allocations for each regional health enterprise. The Ministry of Health and Care Services issues operational directives on general goals to be achieved with those allocations. In consultation with the boards of management of its health enterprises, each regional health enterprise then determines how funds are to be distributed among them. The allocations to health enterprises are accompanied by operational directives from regional health authorities on goals to be reached.

The in-house pharmacies of the state-owned hospitals are administered by four separate Regional Pharmacy Enterprises.

In June 1997, Norway introduced the activity-based funding system for the somatic hospital-based health services based on the DRG (Diagnose Regulated Groups) system. The share of activity-based funding is decided by the Parliament. In 2008, the share of activity-based funding was 40 percent, and 60 percent for block grants.

6.3 Patients rights

The Patients Rights Act stipulates the right to become a patient and receive necessary treatment, as well as several procedural rights.

- All members of the Norwegian population have a right to health care when certain criteria are met
- The health system as such (municipalities, enterprises) and the individual care provider are responsible for providing adequate health care
- Health services must meet minimum standards of adequate quality and safety
- The definition of "adequate standard" will vary with time due to developments in medicine, change in ethical values and prevailing best practice within a certain field
- The patients' entitlement to necessary healthcare in the specialist health care services extends to the right to have care delivered within a specific, individually determined time limit
- Budgetary concerns and providers' priorities cannot be reason to withhold health care treatment

People have several explicit rights as patients, which are based on the principle of patient autonomy and the right to necessary health care:

- Patients have the right to participate in the treatment process, be informed, make their own decisions, and have access to information recorded about them
- Patients also have the right to confidential treatment of personal information
- The Patients Rights Act also stipulates free choice of hospital. The patients cannot, however, choose the type of treatment or how specialized the treatment should be.

6.4 Priority-setting

Priority in the health sector is regulated by law. It defines “necessary care” by taking into account the seriousness of the condition in case and the expected benefit from treatment. Finally, there must be an acceptable equation as to cost and benefit.

The National Council for Quality and Priority-setting advises the Government and the health establishment on issues such as distribution of and access to services, new technology and national guidelines.

Cancer, rehabilitation, diabetes and KOLS are to be given special attention in the period 2007-2011, and a special strategy for the improvement of quality in services has been elaborated for the period 2005-2015. A more recent initiative stems from 2008, aiming at better collaboration in the services, in particular between the specialist services and the municipal health services.

6.5 Pharmaceuticals safe use

Clinical studies have shown that up to 20 percent of patients do not receive correct medication. Errors may occur in all situations in which pharmaceuticals are being handled: during prescription (at physician level), dispensing (in the pharmacy) and at the patients' point of actual use.

Many patients, especially in the older age-groups, suffer from a multitude of diseases requiring complex drug treatment (“poly-pharmacy”). This increases the risk of drug related problems, like interactions, as well as incorrect use of the medication. In addition, studies have shown that inadequate training of health care personnel, lack of routines, proper instructions or unclear responsibilities increase the risk of incorrect use of pharmaceutical drugs.

Correct use of pharmaceutical drugs is promoted through a wide range of recommendations, covering efforts such as paediatric networks, improved dispensing systems and electronic prescriptions.

6.6 Mental health services

Estimates of prevalence of mental disorders in Norway vary considerably, according to methods and diagnostic criteria used. Approximately 15-20 percent of the adult population is estimated to have some kind of mental health problems, while

about three percent is estimated to have a serious mental disorder. The rate of suicide is fairly low in comparison with other Northern European countries. Nevertheless, suicide is one of the most important causes of death for people under 45 years of age, responsible for 13 percent of all deaths in this age group. Of the population aged 6-67 years, three percent receive disability pensions based on a psychiatric diagnosis, constituting one third of all people on disability pension. An additional 0,6 percent of the population is on long term sick leave due to a mental health condition.

The municipalities play a key role in the provision and co-ordination of services for people with mental health problems. Specialised mental health care is provided by the health enterprises. This includes care for patients with serious mental health problems and concurrent drug or alcohol problems (dual diagnoses). Young persons aged 15-30 years with mental health problems and drug abuse are also referred to specialised mental health units.

In 1998, The Norwegian Parliament adopted a reform entitled "National Programme for Mental Health" (1999-2008), including major investments, expansion and reorganizing of services. Central components in the programme are:

- Strengthening the user's position through involvement at all levels in decision-making processes
- information programmes for public awareness on mental health issues
- strengthening community based services with special emphasis on prevention and early intervention
- expanding and restructuring specialized services for children, adolescents and adults.

In primary health care settings the emphasis has been placed on availability of competent services through

- general practitioners for the whole population
- recruitment of psychologists
- establishment of a competency centre for primary mental health services
- educational programmes in mental health for professionals employed in communities.

During the National Programme for Mental Health there has been a marked increase in mental health professionals, which has contributed to better accessibility for out-patient clinic consultations for both children, adolescents and adults. The original goal of 50 percent increase (for adults) has been reached with good margins. An additional contribution has been the systematic establishment of outreach teams. Finally, large scale information campaigns for better understanding of mental health problems have been launched to reduce stigma.

6.7 Alcohol and drug abuse

The medical and social challenges posed by substance abuse are substantial. In addition to structural policies that regulate price and availability of alcohol, much is invested in prevention through the municipal health services. A National Action Plan on Alcohol and Drugs (2007-2010) has been adopted in order to meet the increasing challenges.

6.7.1 Main goals

The aim of the National Action Plan is a policy marked by a clear public health perspective. Main goals include better quality and increased competence, more accessible services and increased social inclusion, binding cooperation, increased user influence and greater attention to the interest of children and family members.

6.7.2 Treatment

The treatment system for drug users is part of the general Health Care System. The Regional Health Authorities are responsible for Interdisciplinary Specialised Treatment (IST). IST indicates the necessity of different health and social welfare system professionals being involved in the treatment. There is a lack of IST treatment slots for both in- and out-patient treatment. The treatment system consists of both public and private institutions, financed by the state through contracts.

Referral to drug treatment is performed either by the general practitioners or by the social welfare system. The referrals have to be dealt with by the IST services within 30 days (stated by The Patients Rights Act), 10 days for drug using patients below the age of 23 years.

Most of the treatment services covers both alcohol and drug using patients, including patients dependent on prescribed drugs.

Medication assisted treatment (MAT) was started on a national scale in 1998. The expansion has been quite rapid, approximately 500 new patients net each year. By the end of April 2008, there were approximately 4,700 patients in MAT with methadone or buprenorphine.

Patients rights have been introduced in order to improve the treatment for substance abusing patients. Emphasis has increasingly been on user's involvement in the treatment process.

7 Public health and health promotion

The general level of health in Norway is high by international standards. However, the socioeconomic distribution of health still poses serious challenges for Norwegian public health policies. Thus, for instance, although life expectancy for Norwegian men in general is among the best in the world, a male university teacher can statistically expect to live some ten years longer than a male chef. Inequalities among female employees are smaller, but still substantial.

7.1 Strategy to reduce social inequalities in health

A 2006 public health white paper, National strategy to reduce social inequalities in health, made the reduction of such health inequalities the central concern of Norwegian public health policy for ten years to come. The strategy was built on the principle that the way to change the social distribution of health is to change the social distribution of health determinants, which are ultimately to be found “upstream”, in the social distribution of resources. More specifically, the strategy operates with four priority areas:

1. Reduce social inequalities that contribute to inequalities in health – including factors such as income, childhood conditions, education, employment and working environment;
2. Reduce social inequalities in health-related behaviour – such as nutrition, physical activity, smoking and substance abuse – and in the utilisation of health services;
3. Targeted initiatives to promote social inclusion; and
4. Develop knowledge and cross-sectoral tools.

Some of these areas are described further below or elsewhere in this document. No less important, however, are the factors outside the traditional limits of the health sector, such as income, education and employment. Thus, a main task in the years to come is cross-sectoral cooperation on issues of socioeconomic distribution.

7.2 Tobacco use and tobacco control

Approximately 6,700 people die from smoking related diseases every year (in particular cardiovascular diseases, cancer and lung diseases), representing 16 percent of all deaths in Norway.

Historically, smoking peaked in Norway around 1970. Since then, there has been comprehensive plan for tobacco control with a designated government agency. Smoking prevalence has declined significantly, while the use of smokeless tobacco has risen since 2000.

7.2.1 Strong legislation

The Norwegian Tobacco Act entered into force in 1975, requiring health warnings on tobacco packaging, 16 year age limit and a ban on advertising of tobacco products. Today Norway is still considered a country with strong tobacco legislation. The EU Directive 2001/37/EC concerning the manufacture, sale and presentation of tobacco products is implemented in national legislation. Like Sweden, Norway has an exception from the EC ban on the sale of tobacco for oral use (moist snuff). The age limit for buying tobacco is 18 years. Since 1988, there has been legal protection from exposure to tobacco smoke in workplaces, only allowing separate smoking rooms. Since 2004, Norway has a complete ban on smoking in bars and restaurants. Norway was the first country to ratify the WHO Framework Convention on Tobacco Control (FCTC), which entered into force in 2005.

7.2.2 Reducing use

The main goal of the National strategy for Tobacco Control 2006-2010 is to promote health in all segments of the population and to ensure more years of healthy life by reducing the use of tobacco. Reducing tobacco use is mainly done in two ways:

- Preventing the uptake of tobacco use: Most important are restrictive measures like legislation and high prices, as well as educational programmes in school and communication measures.
- Smoking cessation: The quit line answers 11 000 calls a year, also offering follow-up calls. Help can also be found through health personnel and cessation courses around the country. Nicotine replacement therapy is available over the counter in general stores.

In the years 1998-2008 daily smoking prevalence among adults decreased from 33 to 21 percent. There has been a remarkable development among young people, where smoking prevalence is cut in half in just five years.

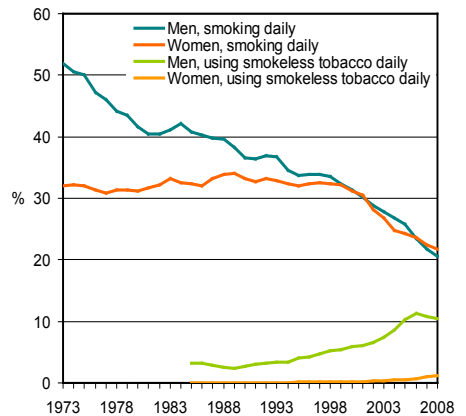


Figure 5 Daily prevalence of smoking and use of smokeless tobacco. Men and women 16-74 years. Statistics Norway.

7.3 Nutrition

In Norway, the population in general has abundant access to food and, at the outset, good opportunities to be able to eat a healthy and varied diet. Developments in the food market are increasing the diversity of products, but can also make it more difficult for people to put together a healthy diet.

The incidence of obesity is increasing due to unhealthy diet and lack of physical activity. Diseases such as type 2 diabetes, cardiovascular diseases, and certain forms of cancer are closely linked to the diet in the population. Social inequalities in diet contribute to the social inequalities in health and disease. Much remains to be done before the diet in all segments of the population meets nutritional recommendations. The diet of many young people and adults still contains too much fat, especially saturated fat, and too much salt and sugar. The consumption of dietary fibre by most people is lower than recommended, and some groups get too little vitamin D, iron and folic acid.

The work to improve the population's diet is outlined in the national nutrition action plan "Recipe for a healthier diet", for the period 2007-2011. The plan contains 73 specific measures that will promote health and prevent illness by changing eating habits. Five main strategies are implemented:

1. Improve the availability of healthy food products

Universal measures that make it easier for everyone to choose healthy foods is the most effective measure to improve healthy eating habits in a population

2. Consumer knowledge

Widely distributed information and communication will help increase the public's knowledge of food, diet and health, which in turn will serve to make it easier for consumers to make informed dietary choices.

3. Qualifications of key personnel

Policy makers and professions who directly or indirectly contribute to nutrition-related activities need to have a sound and relevant level of knowledge about nutrition, diet and food

4. Local basis of nutrition-related activities

In recent years, local partnerships for public health have grown to become one of the most important strategies for a healthier lifestyle. Continuous, binding and systematic interdisciplinary and cross-sectional collaboration is necessary for achieving good health

5. Strengthened focus on nutrition in the health care services

Nutrition is a necessary part of prevention, treatment and rehabilitation of disease, and a basis and support for other medical treatments.

The main topics under consideration in 2008 were development of a sign posting system on foods, marketing of food towards children, healthy meals in kindergarten and schools, provision of vitamin D supplementation to immigrant infants, nutrition among elderly, development of lifestyle intervention and capacity building of key personnel in work places and in the health system.

Twelve ministries have collaborated to develop the current national nutrition action plan, and they all have a co-responsibility in implementing the actions. The action plan serves as a tool for decision-makers, professionals, experts and others in the public and private sectors and in the NGO sector.

7.4 Physical activity

During a relatively short course of time, society has gone through immense changes regarding daily demands of physical activity. Today, we have to actively seek out and give priority to a number of those experiences, challenges and skills that constituted an integral part of everyday life in the past.

The level of physical activity in the Norwegian population is considered to be too low, and there are marked social differences. The World Health Organization points out that physical inactivity will be the great health challenge in the future. Due to lack of physical activity and unhealthy diet the incidence of obesity is increasing, and diseases such as type 2 diabetes, cardiovascular diseases and certain forms of cancer are closely linked to physical inactivity in the population.

To meet the challenge, an Action Plan on Physical Activity (2005-2009) – “Working together for Physical Activity”, was published in 2004. The plan was developed through a co-operation between eight different Ministries, and contains 108 measures. The plan has two main targets:

An increase in the number of children and youth who are physically active for at least 60 minutes pr day

An increase in the number of adults and elderly people who are moderately physically active for at least 30 minutes pr day

An evaluation of the action plan in 2009 will help to decide further actions on promoting physical activity.

8 Universal design - The Delta centre

“Delta” is Norwegian for “participate”. The Delta centre is the national resource centre for participation and accessibility for persons with disabilities. The centre’s activities are based on the Government’s policy on persons with disabilities and on the Standard Rules of the United Nations. The main goal of the Delta centre is to ensure that persons with disabilities can actively participate in society on an equal footing with others. Its vision is participation and accessibility for all.

The work of the Delta centre is based on the combination of universal design, environmental adaptation and assistive technology as methods to facilitate participation and accessibility for persons with disabilities. The main areas of work are to identify disabling barriers and to show how these can be reduced or removed, to develop knowledge on accessibility and to provide counselling on best practise.

User participation is an overarching principle and a strategic method to be employed in all activities at the Delta centre.

9 Preparedness

Health and social preparedness is directed towards the protection of the citizens’ health and social welfare during crises and other unexpected, extraordinary situations.

All preparedness work within the health sector is based on the “principles of responsibility, similarity and proximity”. The organisational unit responsible for a particular task under normal circumstances is obliged by law to prepare for the continuation of its operations during an emergency. The crisis management should be as close to the normal organisation as possible and crises should be handled as close to the scene as the situation permits.

9.1 Aims

It follows from the above mentioned principles that the responsibility for the local and regional preparedness lies with the regional municipal authorities. Guidance is given from the Emergency Preparedness Department based in the

Directorate of Health. The aim is to build a robust, well functioning health and social preparedness system in the municipalities, the counties and the health regions. The following elements shall be mentioned:

- Preparation of national plans and guidance material, including the National Influenza Pandemic Preparedness Plan and the National Smallpox Preparedness Plan
- Supporting regional exercises in the field of health and social preparedness
- Maintenance of a national stockpile of selected medicines, including antivirals against pandemic influenza and potassium iodide against radioactive iodine, a possible contaminant from a nuclear accident
- International, particularly inter-Nordic cooperation, in the field of health preparedness

Links

Action plan on Physical Activity 2005–2009 – “Working together for Physical Activity”, www.1-2-30.no/bedrehelse/handlingsplanen

Norway's National Strategy for Tobacco Control 2006–2010: www.helsedirektoratet.no/tobakk/english

Norwegian Directorate of Health: www.helsedirektoratet.no

Norwegian Institute for Alcohol and Drug Research, SIRUS: www.sirus.no

Statistics Norway: www.ssb.no/english

The Cancer Registry of Norway: www.kreftregisteret.no

The Delta Centre: www.helsedirektoratet.no/deltasenteret/english

The Ministry of Health and Care Services: www.hod.dep.no

The Norwegian Board of Health: www.helsetilsynet.no

The Norwegian Government: www.government.no

The Norwegian Institute of Public Health: www.fhi.no

The Norwegian Medicines Agency: www.legemiddelverket.no

The Norwegian Radiation Protection Authority: www.nrpa.no

The Norwegian Registration Authority for Health Personnel: www.safh.no

Heftet er utgitt av Helsedirektoratet
Postboks 7000 St.Olavs plass, 0130 Oslo.
Flere eksemplarer kan bestilles fra mailadressen
trykksak@shdir.no