Norwegian health system analysis

Organization and governance:

The Norwegian health care system can best be described as a semi decentralized system. Municipalities are in charge of primary care and have the full responsibility of organizing health services on a local level. Since 2002, the four regional health authorities (RHAs) have been under state supervision and have been held responsible for specialist care. Counties' role is confined to statutory dental care.

The Ministry of Health is responsible for regulation and supervision of this framework, however many missions and assignments are mandated to different subordinate organisms. The ministry regulates the activities of its subordinate organisms through direct controlling in the case of national agencies, ownership arrangements such as budgets and letters of instructions (RHAs), and legislation and money-related instruments (counties and municipalities). It guarantees that health and social services are granted in line with national acts and regulations. Recently, inter-sectorial coordination has become an important tool in order to hinder social imbalances in health. In addition, more consideration has been dedicated to improve resource allocation (by emphasizing on the importance of health technology assessment and through priority settings), quality outcomes and patient safety. Since the beginning of 21 st century, reinforcing patients' role has become a top priority, for instance, through an overarching patient rights legislation handling issues such as patient choice and complaint procedures.

Overview of the health system:

The hierarchical structure of the Norwegian welfare system is based on the moral principal of equal access to healthcare services for all inhabitants irrespective of their social, economic or geographical residency. Norway has a three-tier healthcare system: national/state, regional health authorities (RHA) and municipalities (fig1. 2). Counties play a small role in the health-care organization.

The system is managed through an expansive number of acts and secondary legislation. Legislation mirrors the decentralized structure of the welfare system: specialist care is controlled by the Specialist Care Act of 1999 and the Health Authorities and Health trust Act of 2001, dental care is managed by the Dental Health Services Act of 1983 and primary care is regulated by the Municipal Health and Care Act of 2011. Other areas of care that encompass several hierarchical levels are managed by distinct acts: for instance, the Mental Care Act of 1999 and the Public Health Act of 2011. The government determines national priorities and the national budget is negotiated within the parliament. Almost all proposals presented to the parliament are studied in depth by an expert committee. The Standing Committee on Health and Care Services is in charge of matters related to health services, drug and alcohol policy, public health and pharmaceuticals.

The overall responsibility for the health-care sector however, rests at the national level with the Ministry of Health and Care Services. The ministry determines the national health policy, prepares and oversees legislation, decides on the allocation of funds within the health sector (allocation of resources to health and other sectors is the responsibility of the Ministry of

Finance), and implements national health policy with the help of several subordinate institutions (Directorate of Health, 2012c).

The Ministry of Labor plays an indirect role in the welfare system, essentially through the Labor and Welfare Administration (NAV) that regulates various benefits regimens within the National Insurance Scheme (NIS), such as sick leave and disability compensation. The Ministry of Health and the Directorate of Health have been in charge of the healthcare budget in the overall NIS budget plan. This part of the budget is directed by the Norwegian Health Economics Administration HELFO.

Historical Background:

The directorate of Health was founded in 1945 and its work and the general health policy were inspired by the United Kingdom Beveridge Report (Kuhnle, 2006). The foundation of the NIS in 1967 (which was integrated into the NAV in 2006) was an imperative step towards attaining universal coverage of welfare services. TheRegular General Practitioner(RGP) scheme was implemented, giving people the right to choose a general practitioner (GP) of their choice (to be subscribed on the GPs list). Since 2012, theCoordination Reformgave the municipalities a bigger financial responsibility regarding patients who are about to be discharged from hospitals. This reform also aims to amend coordination between the municipal level and the RHAs.

Organization

Central governance of the health system

The ministry of Health puts national health regulations, elaborates major reforms and enforces their applications. The ministry via the RHAs has a direct obligation regarding the procurement of specialist care to patients. In addition, it has administrative control over a number of subordinate agencies (table 2. 1, pages 21 and 47)

Regional health authorities and hospital trust – specialized health care

There are four RHAs in Norway: Northern Norway RHA (Helse Nord), Central Norway RHA (Helse Midt Norge), Western Norway RHA (Helse Vest) and, the biggest, South-Eastern Norway RHA (Helse Sør Øst), covering nearly 55% of the population. The RHAs are in charge of the provision of specialized care and other specialized services including radiology, laboratory and ambulatory services. Presently, there are 27 health trusts managed by the RHAs.

Counties – dental care and public health

In general, the Counties' part in healthcare is restricted. They are primarily in charge of the procurement of statutory dental care.

Municipalities – primary care

Municipalities are accountable for the procurement and financing of primary care. Moreover, they are accountable for a large scope of public health and preventive measures. Municipalities are not under the direct commands of the central authorities and have a lot of flexibility in arranging primary care services.

Private health care sector

The engagement of private actors in primary care is considerable. The majority of the general practitioner is self-employed. However, most GPs are integrated in the public system by contracting with municipalities. On the contrary, private pecuniary providers play a small role in the procurement ofsecondary care: less than 2% of hospital beds are in private profit-making hospitals. Radiology centers and laboratory services remain the major profit-making institutions (80% and 60% of GP referrals for respectively radiology and laboratory services were made to for-profit facilities in 2010) (Directorate of Health, 2012b).

Associations of health care professionals

The major associations are the Norwegian Medical Association (27000 members), the Dental Association (6300) and the Nurses Union (90000). These associations play a double role as trade union and professional associations. As professional associations, they are responsible for a large scope of activities, for example, trainings, education, health policies and ethics. As trade union, they aspire to protect and enhance the financial and professional interests of their members.

Decentralization and centralization (3. 3 pooling of funding)

Scandinavian health care systems are often characterized as being run according to decentralized national health service (NHS) model: funding is raised by taxation and the main actors are public (Rice &Smith, 2002). The

twentieth century saw a considerable delegation of power from central authority to the municipal level, however both tendencies currently co-exist.

“ The funding system for municipalities was changed in 1986 when about 50 different earmarked grants were replaced by block grants” (Ministry of Local Government and Regional Development, 2005). This reform granted municipalities a more prominent level of independence regarding resources allocation across services. Municipalities are also entitled to raise taxes in the interest of financing their activities. In addition, some further decentralization actions were implemented since the beginning of the 21 st century. For instance, the 2000 reform changed the paradigm of hospitals’ management (day-to day running of the hospital is the responsibility of the general manager and executive board) (Johnsen 2006). On the other hand, centralization tendencies can be observed at the same time. The 2002 reforms transferred responsibility for second care from counties to the national level (state). The country was segregated into 5 RHAs (then reduced to 4 in 2007) and hospitals were organized as hospital trusts, which were founded at the same time (Hagen & Kaarboe, 2007). (Sections 3. 3. 3 and 2. 8. 4)

Planning

The National Health Plans is the groundwork planning tool in the welfare area for the coming four years. The plans describe the existing status of the healthcare system, as well as the major challenges, and propose policy goals and actions aimed at meeting them (Nylenna 2007).

Intersectoraility

The coordination of the different measures aimed to improve the overall organization of the healthcare system relies on the interaction of various ministries other than the ministry of Health. The Ministry of Education is concerned with the forecasting of the health workforce, the Ministry of finance is involved through the taxation system and the Ministry of Labor is implicated in the NIS.

Information systems:

National registers gather an extensive scope of healthcare data and cover the entire population (table 2. 2). Collecting data is compulsory for healthcare professionals and it doesn’t entail patients’ consent. At this date, there are 15 central registries in Norway. Hence, the quality of data in these registers is in general considered to be high (NIPH, 2009).

Statistics Norway is the central institution in charge of gathering, examining, and publishing official statistics. Moreover, there are several medical databases (kvalitetsregistere) which gather data about health outcomes and other information concerning specific treatments or diagnoses. These databases give important information to evaluate the impact of different treatment strategies and provide valuable data for research and quality control.

Health technology assessment (HTA)

HTA is under the responsibility of the Norwegian Knowledge Centre for the Health Services (NOKC). This appraisal evaluates both the clinical and cost-effectiveness benefits of a medicine or procedure. The new system launched

in early 2013 is backed by “ mini-HTA “ reports”(assessed at the level of local hospitals), as well as “ full-HTA” reports carried out by the Norwegian Medicines Agency (NoMA) and the NOKC. The purpose of the “ mini HTA” is to guarantee that patients have fast access to innovative and safe hospital treatments.

Priority setting or resource allocation

Regulation:

Regulation and governance of third-party payers

The NIS is the main third party payer in Norwegian welfare system. Its budget is under the control of the Directorate of Health (HELFO). Voluntary health insurance (VHI) is the only other third –party payer in the Norwegian system.

Governance and regulation of specialist care

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The ministry of health is in charge of secondary care through RHAs. However RHAs are independent legal entities, governed by independent boards. The RHAs are responsible of health trusts but health trusts are also separate legal institutions with their own management an executive board.

Regulation and governance of pharmaceuticals

Regulation of pharmaceutical products

The Norwegian Medicines Agency (NoMA) is responsible for granting/withdrawing marketing authorizations and is in charge of post-marketing pharmacovigilance. The regulation of pharmaceuticals comes into agreement with applicable EU regulations since Norway is a member of the EEA. Therefore, there are four relevant procedures that industries should use when requesting marketing authorization: the national procedure, centralized procedure, mutual recognition and decentralized procedures.

Regulation of pharmacies and wholesalers

The 2000 Pharmacy Act shapes the activities of pharmacies in Norway. This act remolded the pharmaceutical environment. First, pharmacist monopole was cancelled (only certified pharmacists can manage pharmacies, however any individual can possess the pharmacy). Second, the restrictions on opening new pharmacies were removed (until 2001 the NoMA adjusted the number of pharmacies). Hence, every drugstore must have two different licenses: one license to possess the pharmacy (the owner’s license) and the second to manage the pharmacy (the operating license). Third, drugstore chains are permitted. Pharmacists have been granted the right for generic substitution since 2001, though only drugs available on the “ substitution list” published by NoMA can be substituted. Only a couple of internet pharmacies are available in Norway and are only permitted to sell OTC medicines.

Policies to improve cost effective use of pharmaceuticals

“ First–choice scheme” is an initiative taken by the government to encourage the usage of generics. Doctors are now compelled to prescribe generic drugs

unless there is a life-threating medical reason that justifies the use prescription of the name brand drug.

Pharmacists are bound to advise patients if there is a less expensive generic drug when their doctor prescribes the original name brand medicine. Patients are obliged to pay the price difference if they insist on buying the originator drug rather than the generic. Higher profits on generic drugs are a key driver for pharmacist to encourage the switch.