European Commission

State of Health in the EU

Norway

Country Health Profile 2021

OECD
BETTER POLICIES FOR BETTER LIVES

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

The Country Health Profile series

The State of Health in the EU's Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

Contents

1. HIGHLIGHTS 3
2. HEALTH IN NORWAY 4
3. RISK FACTORS 6
4. THE HEALTH SYSTEM 8
5. PERFORMANCE OF THE HEALTH SYSTEM 11
5.1 Effectiveness 11
5.2 Accessibility 14
5.3 Resilience 17
6. KEY FINDINGS 22

Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in September 2021, based on data available at the end of August 2021.

Demographic and socioeconomic context in Norway, 2020

Demographic factors	Norway	EU
Population size (mid-year estimates)	5 367 580	447 319 916
Share of population over age 65 (%)	17.5	20.6
Fertility rate[1] (2019)	1.5	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	42 286	29 801
Relative poverty rate[3] (%, 2019)	12.7	16.5
Unemployment rate (%)	4.4	7.1

1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equivalised disposable income. Source: Eurostat database.

Disclaimer: The opinions expressed and arguments employed herein are solely those of the authors and do not necessarily reflect the official views of the OECD or of its member countries, or of the European Observatory on Health Systems and Policies or any of its Partners. The views expressed herein can in no way be taken to reflect the official opinion of the European Union.

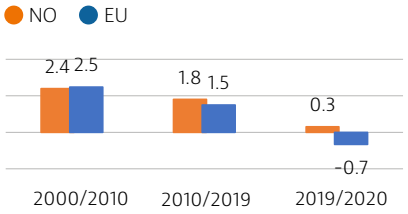
This document, as well as any data and map included herein, are without prejudice to the status of or sovereignty over any territory, to the delimitation of international frontiers and boundaries and to the name of any territory, city or area.

Additional disclaimers for WHO apply.

© OECD and World Health Organization (acting as the host organisation for, and secretariat of, the European Observatory on Health Systems and Policies) 2021

1 Highlights

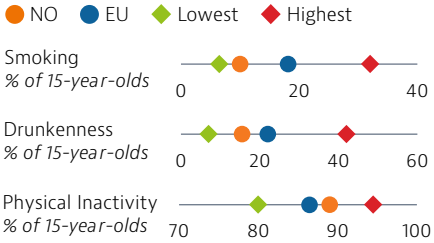
Life expectancy in Norway was the highest in Europe in 2020, as the country was less affected by the COVID-19 pandemic in the first year than nearly all other European countries. Infection and death rates from COVID-19 in 2020 were low, thanks to rapid and strong containment measures. The health care system provides universal access to high-quality care. Long waiting times for specialty care remain a challenge. Health spending per capita is the highest in Europe.



Life expectancy gains, years

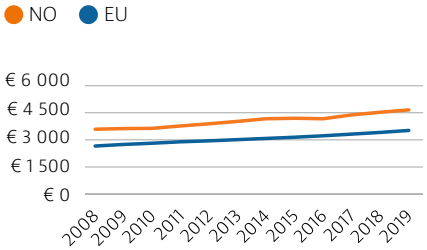
Health Status

Life expectancy in Norway was the highest in Europe in 2020, at 83.3 years. Norway is one of just three European countries where life expectancy increased in 2020. The increase in life expectancy observed between 2010 and 2020 in Norway was greater than that observed in most EU countries, mainly driven by reductions in mortality from cardiovascular conditions.



Risk factors

Behavioural risk factors contribute to a smaller share of deaths overall than the average across EU countries. Smoking rates and alcohol use are lower than in the EU overall. However, increasing overweight, physical inactivity and use of snus (a smokeless oral tobacco product) among adolescents are areas for public health improvement.



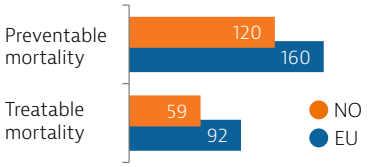
Per capita spending (EUR PPP)

Health system

Per capita spending on health in Norway has remained among the highest in Europe for a decade, although spending as a share of GDP is only slightly above the EU average. The share of public spending is also the highest in Europe, at 86 % in 2019. Between 2015 and 2019, health expenditure grew by around 2.5 % per year in real terms. In 2020, despite the COVID-19 pandemic, overall growth in health spending was slower than in previous years, but GDP fell by 2.5 %.

Effectiveness

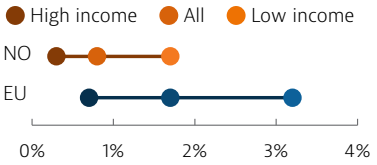
Mortality from preventable causes in 2018 was lower in Norway than in the EU. This reflects an effective public health and primary care system, as well as relatively healthy lifestyles. Norway also has one of the lowest rates of deaths from treatable causes, reflecting good access to effective, high-quality treatments.



Age-standardised mortality rate per 100 000 population, 2018

Accessibility

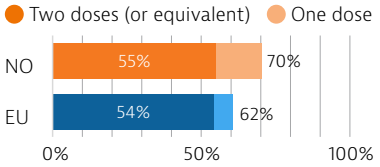
Access to health care is generally good in Norway. In 2019, fewer than 1 % of adults reported forgoing needed medical care, which is about half the EU average. Unmet dental care needs are higher. Elective care was delayed during the first COVID-19 wave, and some delays in cancer screenings were reported. A surge in use of teleconsultations helped maintain access to ambulatory care during the pandemic.



% reporting unmet medical needs, 2019

Resilience

Norway faced lower COVID-19 case and death rates than most EU countries, because of rapidly implemented containment measures, low population density, high levels of trust in government, a responsive health care system and generous social welfare arrangements. By the end of August 2021, 55 % of the population had received two doses (or equivalent) – a proportion close to the EU average.



Share of total population vaccinated against COVID-19 up to the end of August 2021

2 Health in Norway

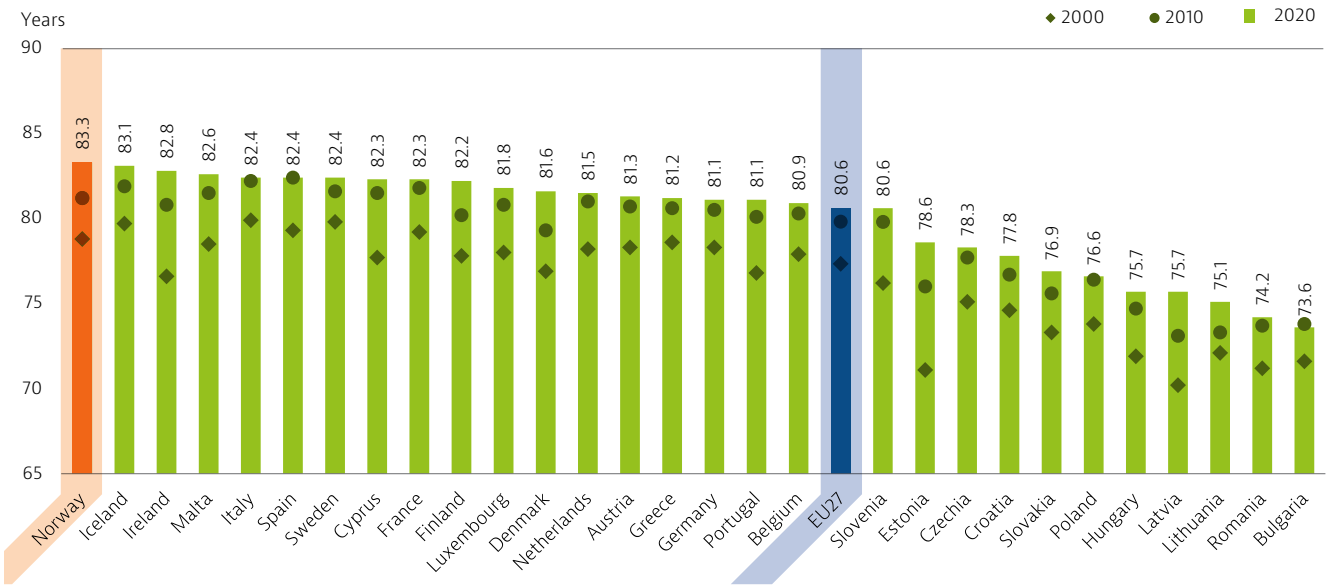
Life expectancy in Norway was the highest in Europe in 2020

Life expectancy at birth in Norway has increased steadily over the past two decades to 83.3 years in 2020 – higher than in any EU country and 2.7 years above the EU average (Figure 1). Women live 3.3 years longer than men on average (84.9 compared to 81.6 years). This gender gap is much smaller than the EU average (5.6 years).

Norway was one of only three European countries where life expectancy increased in 2020 despite the COVID-19 pandemic. Although the majority of COVID-19 deaths were among older adults (81 % of deaths were among people aged 70 and over as of mid-July 2021), life expectancy increased even in the group of those aged 80 and older (Statistics Norway, 2021). Overall, the COVID-19 death rate was nearly nine times lower in Norway than the average across EU countries in 2020 (84 deaths per million population compared to 744 deaths).

No excess mortality was reported in 2020. In fact, the number of deaths in 2020 was lower than that in 2019. These trends are mainly due to a responsive and flexible health system and rapidly implemented containment measures (see Section 5.3), which also contributed to lower rates of non-COVID-19 deaths, such as from cardiovascular and respiratory conditions (FHI, 2020a).

Figure 1. Life expectancy in Norway is more than two years higher than the EU average



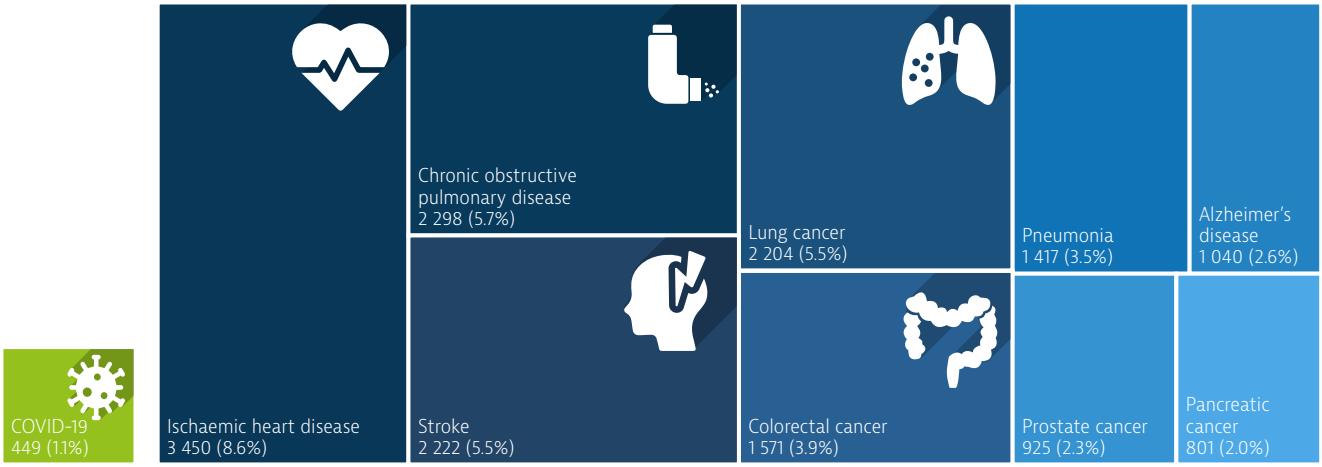
Note: The EU average is weighted. Data for Ireland refer to 2019.
Source: Eurostat Database.

Circulatory diseases, respiratory diseases and cancer are the main causes of death in Norway

The gains in life expectancy over the past two decades in Norway have been driven to a large extent by reductions in mortality rates from circulatory diseases. Nevertheless, ischaemic heart disease remained the main cause of death in 2018, representing 8.6 % of deaths (Figure 2). This was followed by chronic obstructive pulmonary disease (COPD), stroke and lung cancer, each of which represented between 5.5 % and 5.7 % of total deaths.

Lung cancer is the most frequent cause of death from cancer, followed by colorectal cancer. COVID-19-related deaths represented 1.1 % of all deaths in 2020 – a much smaller share than in most European countries.

Figure 2. Ischaemic heart disease is the leading cause of death in Norway

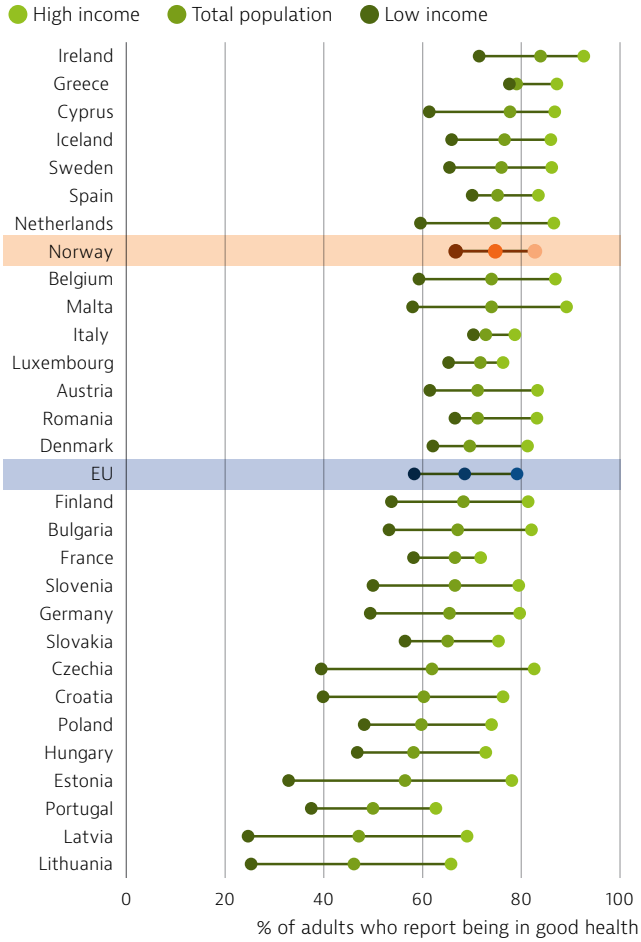


Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2018. The size of the COVID-19 box is proportional to the size of the other main causes of death in the previous year.
Sources: Eurostat (for causes of death in 2018); ECDC (for COVID-19 deaths in 2020, up to week 53).

Most Norwegian people report being in good health, but more than one third have a chronic condition

Three quarters of people reported being in good health in 2019, which is a higher proportion than in most EU countries (Figure 3). While individuals in the lowest income quintile were less likely to report being in good health (67 %) than those in the highest (83 %), this gap was smaller than in most other European nations. Nevertheless, more than one third of Norwegian adults (37 %) reported having at least one chronic condition in 2019 – a proportion similar to the EU average (37 %), according to EU-SILC. As with self-reported health, there was income inequality, with 43 % of individuals in the lowest income quintile reporting having chronic conditions, compared to 30 % of those in the highest.

Figure 3. Self-reported health status is generally good, with relatively small income inequalities



Note: 1. The shares for the total population and the low-income population are roughly the same.
Source: Eurostat Database, based on EU-SILC (data refer to 2019).

3 Risk factors

Behavioural risk factors contribute to approximately one third of deaths in Norway

Behavioural risk factors contributed to about one third of deaths in Norway in 2019, with dietary risks and tobacco use being the main contributors (Figure 4). Dietary patterns such as low fruit and vegetable intake and high sugar and salt consumption are estimated to contribute to 13 % of all deaths – a smaller share than in the EU overall (17 %).

Tobacco consumption, reflecting direct and second-hand smoking, was responsible for an estimated 12 % of all deaths, which is also less than the EU average. Alcohol consumption was estimated to contribute to 3 % of deaths – about half the EU average share (6 %). Low physical activity levels contributed to an estimated 2 % of deaths, which is similar to the EU average. Air pollution in the form of fine particulate matter (PM2.5) and ozone exposure alone accounted for 1 % of all deaths – about four times lower than the EU average.

Figure 4. Dietary risks and tobacco are important contributors to mortality

Note: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to PM2.5 and ozone.
Source: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Obesity levels are lower than the EU average, but an increase in adolescent obesity is a concern

Nearly one in seven (14 %) adults in Norway were obese in 2019, up from one in twelve (8 %) in 2002, but this rate remains lower than the EU average (16 %). Norwegian adults are more physically active than those in most EU countries, although more than one in five did not meet the WHO recommendation of at least 2.5 hours of moderate physical activity each week in 2014.

More than one in six (18 %) Norwegian 15-year-olds was overweight or obese in 2018; this is similar to the EU average (19 %), but represents an increase from 2013/14 (13 %)[1]. Physical activity levels and rates of fruit consumption among Norwegian 15-year-olds are lower than the EU averages, potentially contributing to weight problems.

Tobacco smoking has decreased but oral snus tobacco remains popular among young adults

Smoking rates in Norway are lower than in most EU countries. Among adults, just 9 % reported daily tobacco smoking in 2020, compared to an EU average of nearly 20 %. Considerable progress has been made since 2000, when 32 % of adults were daily smokers. Socioeconomic differences in smoking are stark, however: the adults with the lowest education levels are 4-5 times more likely to report daily smoking than those with the highest.

Among adolescents aged 15-16 years, 10 % reported having smoked cigarettes in the past month in 2018, compared to 18 % in the EU on average. As with adults, significant reductions have been achieved in recent decades, with just 2.5 % reporting daily tobacco smoking in 2019 compared to 24 % in 1999.

1. These data from the 2017/2018 Health Behaviour in School-Aged Children survey differ slightly from those reported by the Norwegian Public Health Institute for 2018 (17 %), 2011 (18 %) and 2005/6 (14 %).

Norway has one of the most comprehensive tobacco control policies in Europe, including the highest tobacco prices, standardised plain packaging with health warnings and a ban on visible display of tobacco products in shops.

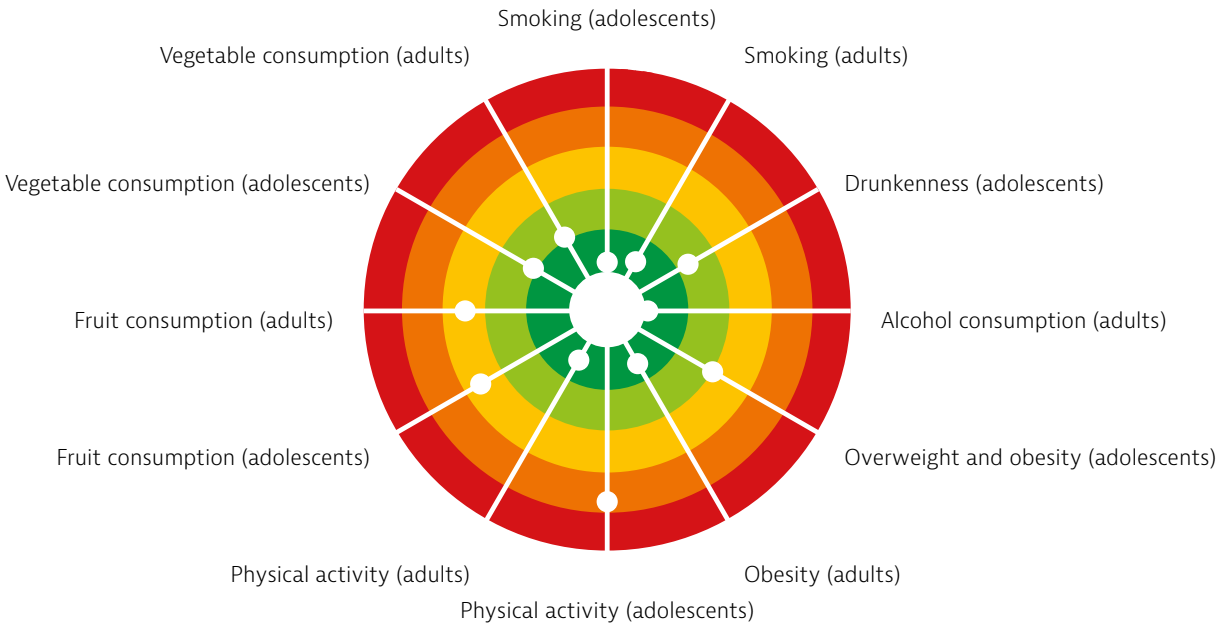
The use of snus, an oral smokeless powder tobacco product, has become increasingly common over the past two decades, particularly among young people. In 2020, around 14 % of women and 25 % of men aged 16-24 reported being daily users, compared to 0 % of women and 7 % of men in 2000 (FHI, 2020b). Its increasing popularity has been attributed to lower prices relative to cigarettes (because of lower taxation), relatively high nicotine levels, use of flavourings and a variety in packaging sizes (including mini-portions).

Alcohol consumption among both adults and adolescents is relatively low

Norwegians consume less alcohol than the populations of any EU country (Figure 5), and consumption has fallen by approximately 5 % since 2000. In 2019, average consumption was 6.1 litres of pure alcohol per capita, which is 40 % less than the EU average of 10.1 litres. Consumption among adolescents is also much lower than in most EU countries: just 16 % of 15-year-olds reported having been drunk more than once in their lifetime in 2018, compared to an EU average of 22 %.

A number of policies contribute to lower alcohol use. Chief among these are high alcohol prices, which are among the highest in Europe, due to high taxation. Access is controlled through a state-owned monopoly chain of liquor stores, which are the only retail sites allowed to sell alcoholic beverages containing more than 4.75 % alcohol by volume, restricted selling hours of beer and cider in supermarkets, and a ban on selling alcohol at kiosks and gas stations. Alcohol advertising is banned, as are happy hours in bars and restaurants.

Figure 5. Physical inactivity among adolescents and low fruit consumption are public health concerns



Note: The closer the dot is to the centre, the better the country performs compared to EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.
Sources: OECD calculations based on HBSC survey 2017-18 for adolescents indicators; OECD Health Statistics, EHIS 2014 and EHIS 2019 for adults indicators.

4 The health system

The state and municipalities share responsibilities for health care planning and delivery

Norway has a tax-based national health system with semi-decentralised governance. The state is responsible for hospital and specialist care services, which are organised through four regional health authorities (RHAs) in charge of hospital and pharmacy trusts in their region. Municipalities are responsible for primary care and public health which include services such as general practitioners (GPs), maternity and child health centres, school health services and immunisation centres, in addition to long-term care and social services. Counties' role is limited to providing dental care for children and some vulnerable populations. Central direction from the Directorate of Health, an executive agency and authority under the Ministry of Health, and advice from the Public Health Institute – Folkehelseinstituttet (FHI) – were key to Norway's COVID-19 response (Box 1).

Box 1. The Directorate of Health coordinated the health system response to COVID-19

The 2000 Emergency Health Preparedness Act gives the Directorate of Health responsibility for overall coordination of the health system's response to an emergency. Even before the provisions of the Act were triggered (March 2020), the Ministry of Health and Care Services delegated this responsibility to the Directorate (January 2020).

In March 2020, emergency legislation – the Coronavirus Act – was passed, which gave the central government greater powers to carry out necessary containment measures, such as closing national borders. The legislation ended in May 2020, but several provisions continued in force through temporary laws enacted in Parliament during regular proceedings, and many of these were extended until November 2021.

In May 2020, responsibility for development and implementation of sector-specific regulations was transferred back to the relevant ministries.

The FHI and the National Preparedness Commission Towards Biological Threats were key advising bodies throughout the pandemic, including to central and municipal governments.

Source: Saunes et al. (2021).

The health system is overwhelmingly funded through public sources

In 2019, Norway spent 10.5 % of GDP on health, which is in line with other Scandinavian countries and slightly higher than the EU average. At EUR 4 661 (adjusted for differences in purchasing power), health spending per capita in 2019 was the highest in Europe, and over 30 % higher than the EU average (EUR 3 521) (Figure 6). Health expenditure grew at a rate of about 2.5 % per year in real terms between 2015 and 2019. A range of levers help to contain costs, including the use of budgeting, largely salaried health personnel, health technology assessment and price-setting tools. During the COVID-19 pandemic, a special allowance was made for national health expenditure to exceed budgeted amounts, reflecting additional costs (Box 2).

Public spending on health includes both tax revenues from national and municipal sources and payroll contributions to the national insurance scheme, shared between employees and employers. Public spending, accounting for 85 % of total health spending – a higher share than in any EU country – has grown more rapidly than GDP over the past decade. Private expenditure, which in Norway consists mainly of out-of-pocket (OOP) spending by households, made up the remaining 15 %.

Spending on long-term care is the highest in Europe

In 2019, Norway allocated roughly the same amount of health spending on inpatient care, outpatient care and long-term care – just under 30 % of the total for each spending category. The proportion spent on long-term care was higher than in any EU country (Figure 7). In contrast, the share of total health spending on retail pharmaceuticals and medical devices of just over 10 % was the lowest, and had decreased over the past decade. This figure does not include pharmaceutical and medical device expenditure in hospitals, which is reported under inpatient or outpatient care. Spending on prevention accounted for about 2.5 % of all health spending, which is close to the EU average.

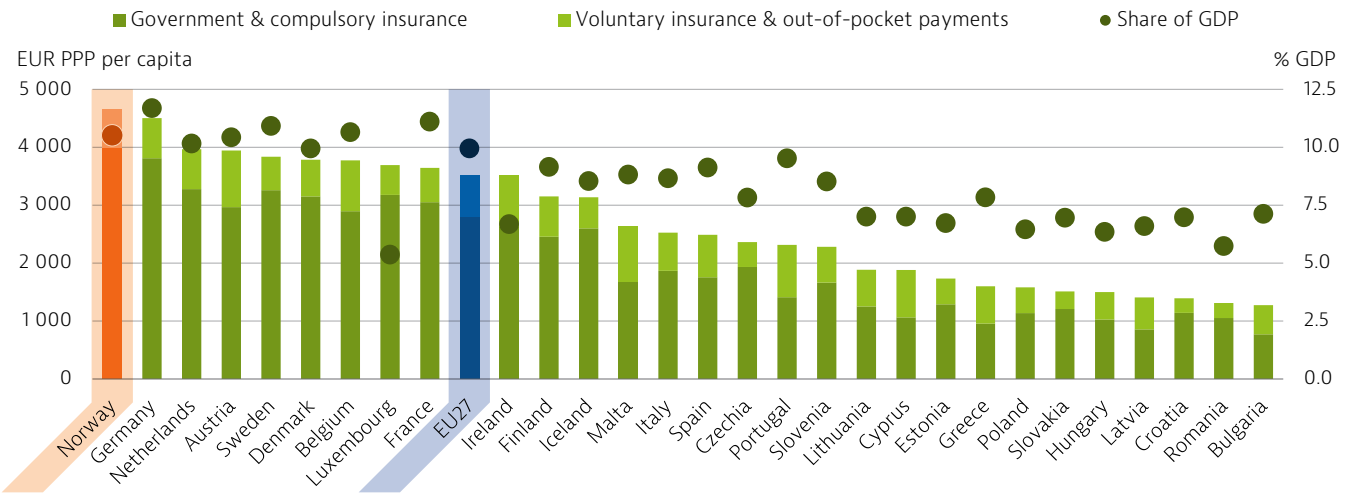
Box 2. Municipalities received substantial funding injections for the COVID-19 response

In mid-March 2020, extraordinary permission was given for national spending to exceed the budgeted amount for 2020, to help cover expenses towards handling the outbreak (Coronavirus Commission, 2021).

In April 2020, the government announced an injection of NOK 3.9 billion (EUR 327 million) to municipalities to help cover increased health care expenses related to COVID-19 as well as towards testing, contact tracing, isolation and quarantine costs. This funding was subsequently increased, including in September 2020, when case rates started increasing again.

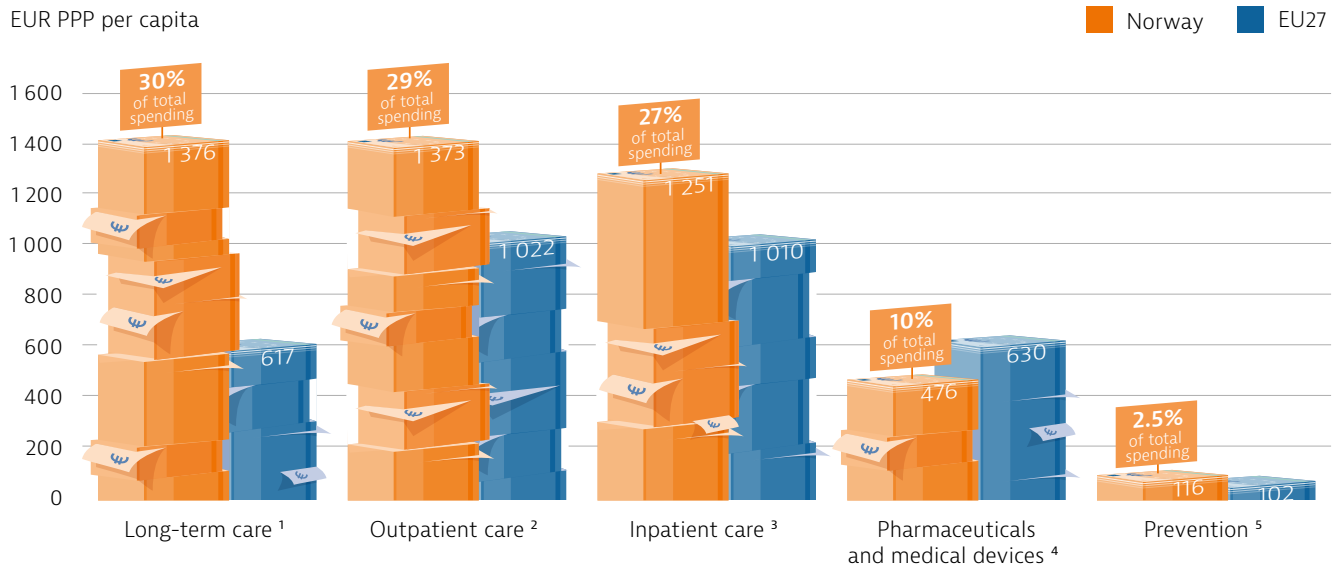
Despite these funding injections, preliminary calculations suggest that in 2020 overall health expenditure grew at a lower rate than in previous years, in part due to lower activity levels during March-April 2020 in the hospital and specialty care sector, and in dentist and physiotherapy services (Monsrud, 2021). The health budget for 2021 was increased by about 9.5 % compared to 2020.

Figure 6. Per capita spending on health is the highest in Europe



Note: The EU average is weighted.
Source: OECD Health Statistics 2021 (data refer to 2019, except Malta 2018).

Figure 7. Norway spends more on long-term care than other European countries



Note: The costs of health system administration are not included. 1. Includes only the health component; 2. Includes home care and ancillary services (e.g. patient transportation); 3. Includes curative-rehabilitative care in hospital and other settings; 4. Includes only the outpatient market; 5. Includes only spending for organised prevention programmes. The EU average is weighted.
Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019).

An annual cap reduces the burden of out-of-pocket payments for heavy users of health services

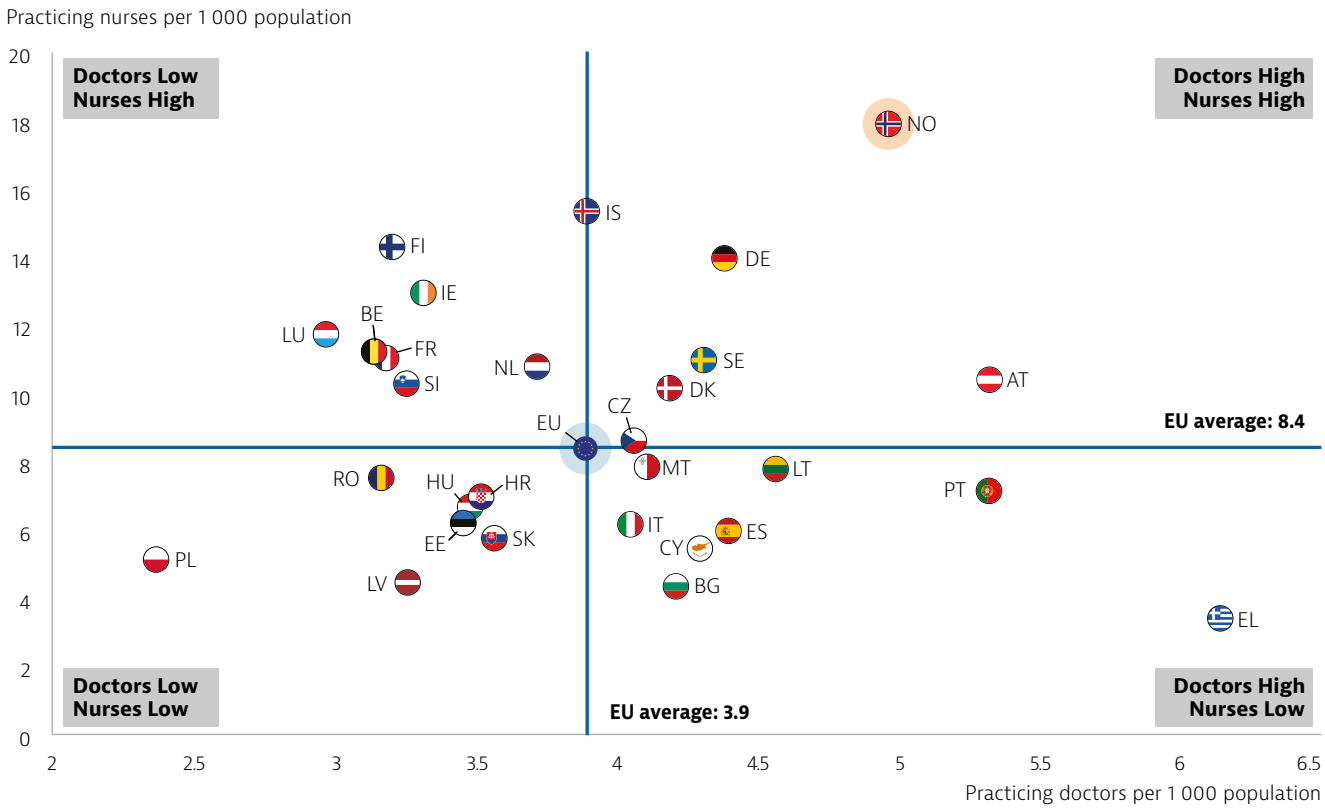
Health coverage among Norwegian residents is universal and automatic. While the benefits package covers a broad range of services, most except inpatient care (including prescribed medicines) and home-based nursing care require some level of cost-sharing – mainly in the form of co-payments. Children under the age of 16, pregnant women, people receiving low pensions and those injured in occupational accidents are exempted from co-payments. Adult dental care and outpatient pharmaceuticals are the main sources of OOP spending, each accounting for around one quarter of total OOP spending in 2019.

Until 2021, two separate annual spending caps applied: one for physician and psychologist visits and prescription drugs; and another for physiotherapy, rehabilitation and (some) dental care. In January 2021, these caps were merged, with NOK 2 460 (EUR 235) applying to all these services. Once this cap has been reached, no further cost-sharing applies for covered services.

Norway has high numbers of both doctors and nurses

Although Norway has more doctors per 1 000 population than most EU countries (Figure 8), the uneven geographical distribution of GPs and shortages in some areas are a problem. The number of nurses per capita has increased over the past two decades and is also well above the EU average, but the workforce dropout rate for nurses is high, especially among those working in long-term care. This has led the government to introduce a number of measures to secure the nursing supply in future years.

Figure 8. The Norwegian health system has among the highest number of health professionals



Note: The EU average is unweighted. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: Eurostat Database (data refer to 2019 or the nearest year).

The supply of hospital and intensive care unit beds was low before the COVID-19 pandemic

Most hospital care in Norway is provided through 20 public hospital trusts, which are state owned and governed as publicly owned corporations through RHAs. Prior to the COVID-19 pandemic, the proportions of both acute (310 per 100 000 population) and intensive care unit (ICU) beds (5.5 per 100 000) in hospitals were lower than the EU averages (360 acute beds per 100 000 and 12.9 ICU beds per 100 000), while the occupancy rate of acute care beds was 80 % – one of the highest in Europe.

These data suggest a generally efficient use of hospital resources, but one that left limited buffer capacity to cushion a large surge in demand for hospital care. Even though pre-existing acute and ICU bed capacity was never saturated during the COVID-19 pandemic, Norwegian authorities commissioned the RHAs to develop detailed plans to increase capacity for both, in anticipation of a possible major surge in admissions (see Section 5.3).

Patients can choose health providers, but general practitioners act as gatekeepers to hospital care

Norwegian GPs are mostly self-employed and contracted by municipalities. They typically work in group practices of two to six physicians alongside nurses and other personnel, and are responsible for delivering care outside working hours on a rotational basis. GPs act as gatekeepers to specialist and hospital care, and patients are free to choose among any public and approved private providers, and general and specialised hospitals.

In 2015, freedom of choice of hospital was extended to any hospital in the EU or European Economic Area (EEA), although transportation costs are not covered.

Care has shifted to outpatient settings, focusing on patient-centred provision and care coordination

Thanks to concerted policy efforts, care provision in Norway has gradually shifted from inpatient to outpatient settings. As a result, average hospital lengths of stay are now among the lowest in Europe, at 6.4 days in 2019 – down from 8.9 in 2000. The National Health and Hospital Plan 2020-23 includes a number of measures to strengthen patient-centred provision of health services, including the creation of 19 health care communities to coordinate better between municipal and hospital services, and expansions in digital care. A new model of multidisciplinary primary care teams is also being piloted during 2018-23 (see Section 5.1).

5 Performance of the health system

5.1 Effectiveness

Low rates of preventable deaths suggest strong primary care and public health systems

Norway has low rates of deaths from causes that can be largely avoided through public health and primary prevention interventions, compared to most countries in Europe (Figure 9). Among these, lung cancer and chronic lower respiratory diseases were the leading causes, reflecting a legacy of high smoking rates in previous generations. Between 2011 and 2018, rates of preventable deaths declined by 17 % overall. This reflects efforts by municipal governments, which are responsible for primary care, public health and health promotion (see Section 4). GPs also play a role in health promotion, and can prescribe physical activity for people who want to adopt healthier behaviours.

The number of treatable causes of deaths is one of the lowest in Europe

Norway also has relatively low rates of deaths from treatable causes (Figure 9). In 2018, the overall rate of such deaths was the second lowest in Europe, and it had decreased by 22 % since 2011.

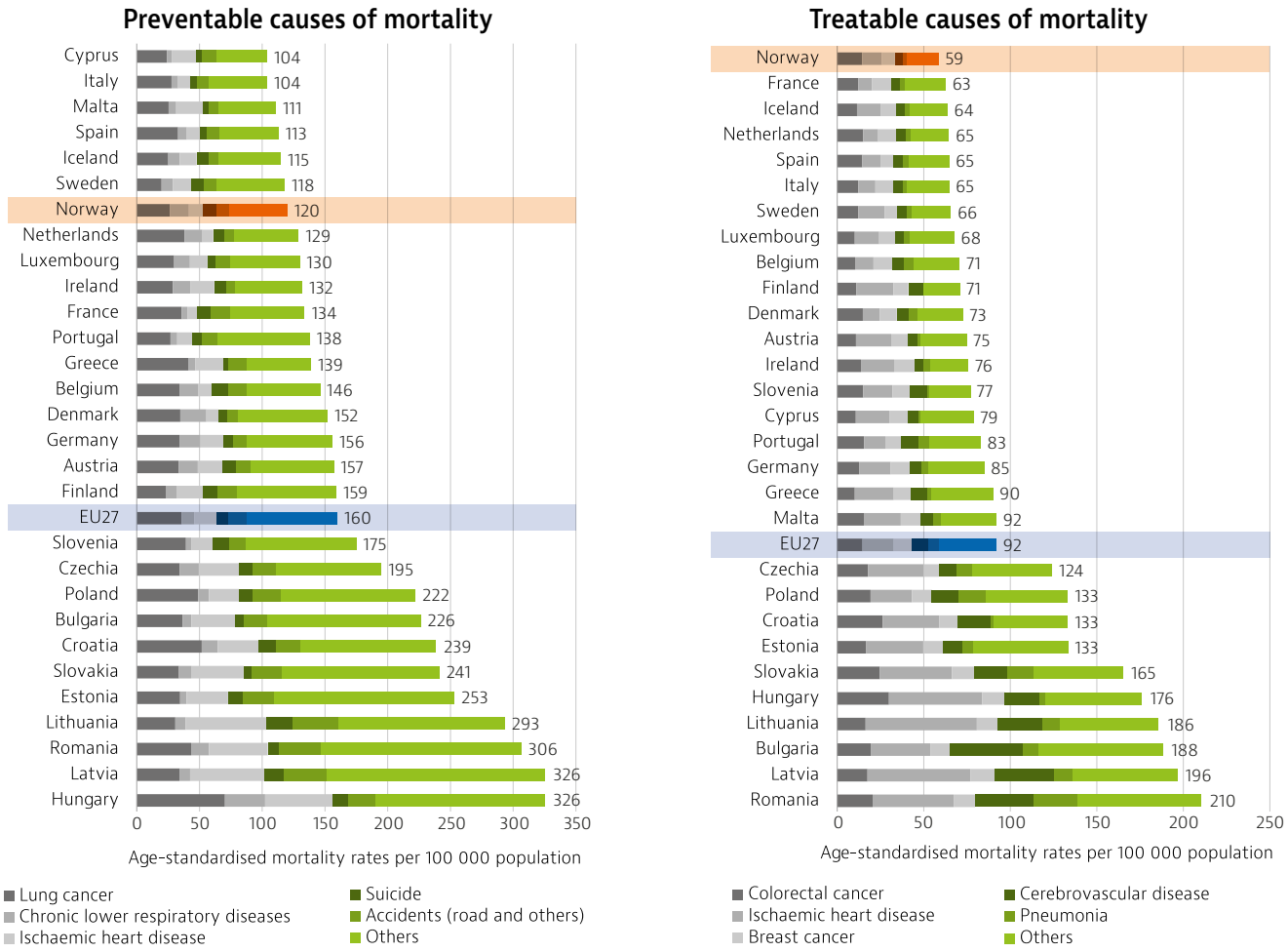
This low rate, which partly reflects a lower incidence of these diseases in the Norwegian population compared to most EU countries, indicates that the Norwegian health care system provides access to effective and timely diagnoses and high-quality treatment for life-threatening conditions.

Norway has strengthened the quality of and access to timely specialty care – for example, through the introduction of standardised patient care pathways for certain diseases for which well-established treatments exist, including cancers and stroke, as well as musculoskeletal, mental health and substance use conditions. These were introduced following the 2012 Coordination Reforms.

There is scope to reduce avoidable hospitalisations through strengthened care coordination

Norway has low rates of avoidable hospital admissions from diabetes and congestive heart failure compared to most European and Nordic countries (Figure 10). However, hospitalisations for respiratory conditions such as asthma and COPD are slightly above the EU average.

Figure 9. Mortality from preventable and treatable causes is among the lowest in Europe



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.
Source: Eurostat Database (data refer to 2018, except for France 2016).

To improve care coordination, follow-up and monitoring of patients with chronic conditions, a new model of multidisciplinary primary care teams including nurses and health secretaries is being piloted during 2018-23. In recent years, hospitals have been given greater responsibility in coordinating discharges – for example, through the creation of discharge checklists and the requirement to coordinate patient follow-up with municipalities. In 2019, health care communities were launched, representing partnerships between municipalities and hospital trusts. These communities are tasked with joint planning and target-setting and improving coordination between hospital-based, municipal (GP, dental, long-term care and physiotherapy), community mental health and private hospital services.

Figure 10. Norway has low avoidable admissions from diabetes and congestive heart failure, but rates for respiratory conditions are above EU average

Age-standardised rate per 100 000 population aged 15+

Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

Cancer survival rates are high

Norway's cancer survival rates are high compared to EU averages for several common cancer types (Figure 11), and rates have improved since 2000-04 for most cancer types. National screening programmes for breast cancer (since 2005) and cervical cancer (since 1995) have contributed to earlier diagnosis. A national colon cancer screening programme will be implemented starting in late 2021.

Cancer patient pathways were introduced in 2015 to improve care quality for 28 different types of cancer, reflecting a standardised, evidenced-based course of care that include maximum waiting times for each step and designate a pathway coordinator responsible for continuity of care. A recent evaluation showed that waiting times for radiotherapy improved for several types of cancer between 2007 and 2016 (Nilssen et al., 2020).

The current national cancer strategy for 2018-22, "Living with Cancer", focuses on improving quality of life for cancer patients, survivors and their families; improving care coordination; boosting prevention measures; and increasing treatment capacity. Many of these measures align with those prioritised in the new Europe's Beating Cancer Plan from the European Commission (2021).

Figure 11. Five-year cancer survival rates are higher in Norway than across EU countries on average

Prostate cancer
Norway: 93 %
EU23: 87 %

Breast cancer
Norway: 87 %
EU23: 82 %

Cervical cancer
Norway: 73 %
EU23: 63 %

Colon cancer
Norway: 65 %
EU23: 60 %

Lung cancer
Norway: 18 %
EU23: 15 %

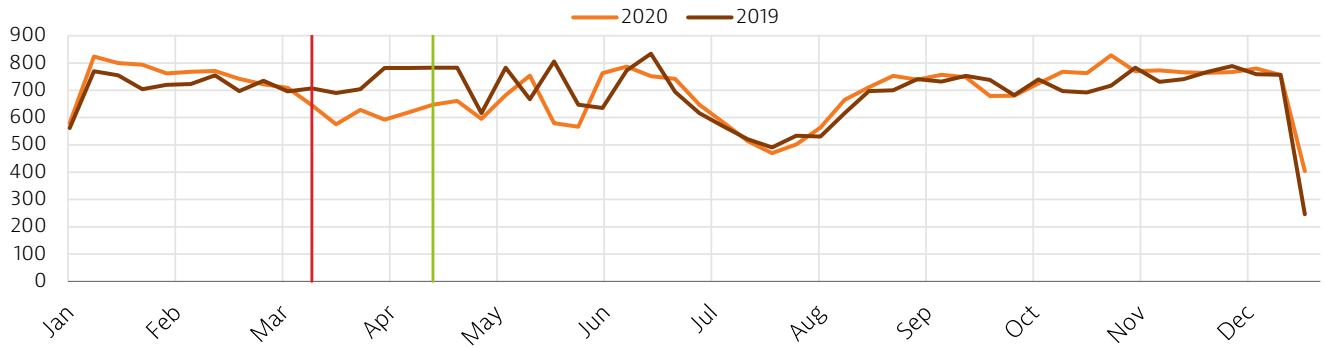
Note: Data refer to people diagnosed between 2010 and 2014. Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

The COVID-19 pandemic disrupted cancer screening and some treatments

When the pandemic erupted in March 2020, health providers were instructed to postpone cancer screening to prioritise urgent care and reduce the risk of COVID-19 spreading in health care settings. Breast and cervical cancer screenings were resumed starting in May 2020, and both programmes had resumed their regular schedules by August 2020. More generally, the rate of detecting new cancer cases normalized towards autumn 2020 following some delays during early phases of the pandemic (Figure 12; Larønningen et al., 2021).

Cancer treatments were disrupted relatively little, since early instructions from the government were to prioritise these patients. Despite volume reductions in March-April 2020, most treatment activities had resumed to regular levels by September 2020 (SKDE, 2020) and more patients enrolled in cancer pathways completed their treatment in the specified time-frames in 2020 than in 2019 (Coronavirus Commission, 2021).

Figure 12. The number of cancer diagnoses dropped in spring 2020 but normalized towards the end of the year



Note: This figure shows new cases of cancer reported to the Norwegian Cancer Registry in 2019 and 2020, including malign, benign and precancerous stages. The red vertical line indicates national lockdown (12 March 2020), after which cancer screenings were postponed. The green vertical line represents mid-April 2020 when the government started gradually opening up society again.
Source: Norwegian Cancer Registry (2021).

5.2 Accessibility

Population coverage is universal, with a generous benefits package

Norway's health system offers universal coverage to all legal residents, as well as EU and EEA residents and Australians, through bilateral agreements. For undocumented migrants, basic services such as vaccinations and examinations are covered for children, while only emergency acute care is covered for adults. The benefits package is generous and includes physiotherapy and dental care for children, with partial coverage for adolescents aged up to 20.

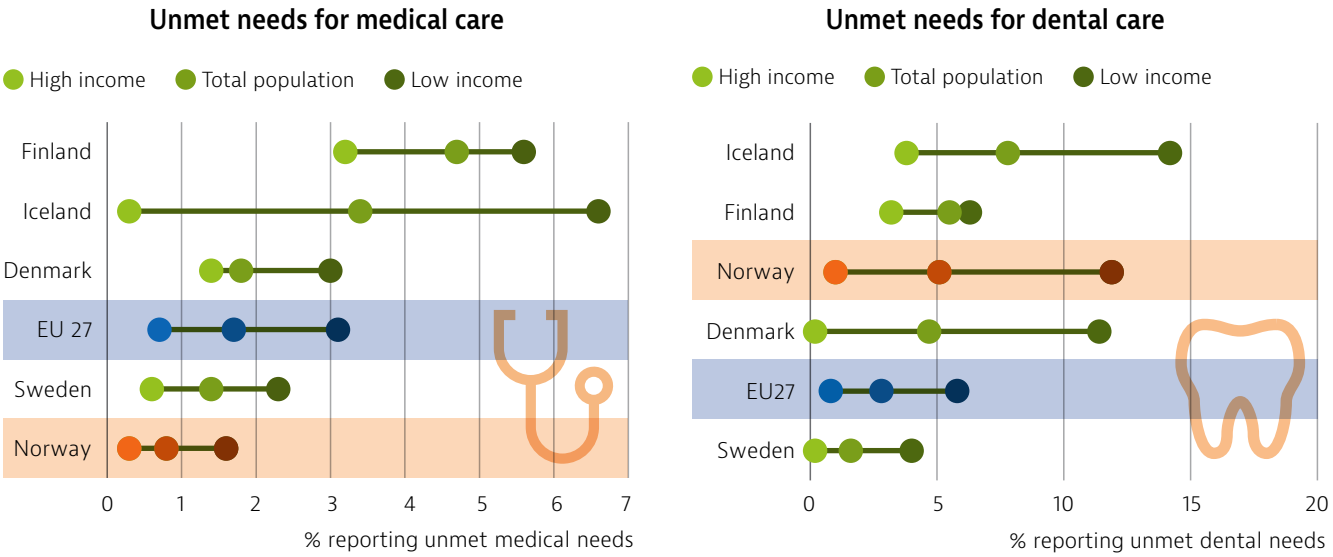
The extent of coverage, measured as a share of total expenditure covered by national insurance, is more generous than in the EU on average for inpatient and outpatient services, and therapeutic appliances. Coverage levels for dental care and pharmaceuticals are slightly below the EU average.

Unmet needs for medical care are generally low, but are higher for dental care

Fewer than 1 % of Norwegians reported unmet needs for medical care in 2019, with waiting times the main reason. This was the lowest rate among Nordic countries, and approximately half the EU average. Individuals in the lowest income quintile more often reported unmet needs than those in the highest, although Norway had the smallest absolute inequality by income among Nordic countries (Figure 13).

Unmet needs for dental care are more common: about 5 % of the population reported this in 2019, mainly for financial reasons. Norway had the largest income difference among Nordic countries, with 12 % of residents in the lowest income quintile reporting unmet dental needs compared to just 1 % of those in the highest. Adult dental care is largely excluded from national coverage, except for individuals with mental health or long-term conditions.

Figure 13. Unmet needs for medical care are low, but large income inequalities exist for dental care



Note: Data refer to unmet needs for a medical or dental examination or treatment due to costs, distance to travel or waiting times.
Source: Eurostat Database, based on EU-SILC (data refer to 2019, except Iceland 2018).

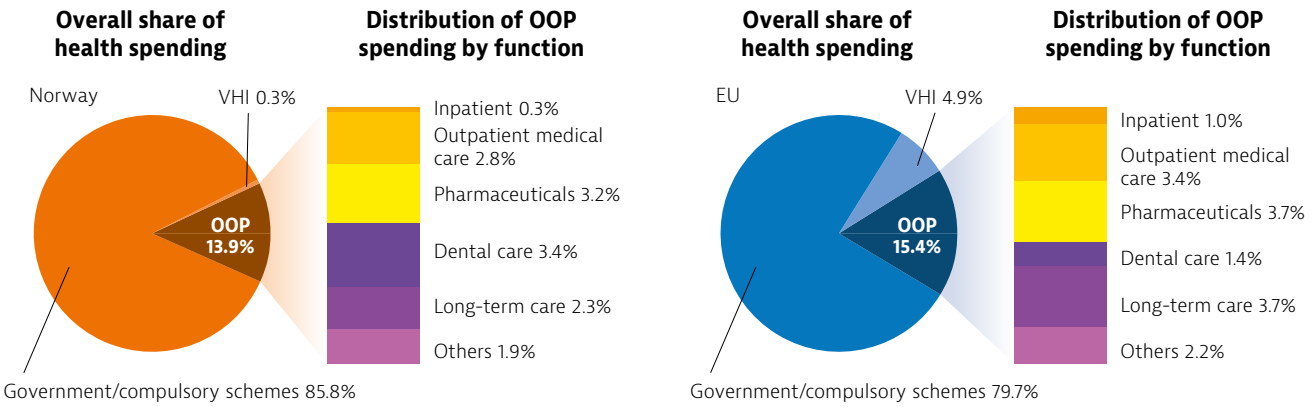
Out-of-pocket spending is mainly on pharmaceuticals and dental care

OOP spending represents about 14 % of expenditure – a slightly lower share than the EU average (Figure 14). There is no cost-sharing for inpatient hospital services, home-based nursing care or services rendered to children and pregnant women. Most other services require a moderate co-payment (see Section 4). Outpatient pharmaceuticals and dental care represent about half of OOP spending. The merging of OOP ceilings for physician, pharmaceutical, physiotherapy and dental services (see Section 4) in 2021 is expected to lower OOP costs for patients who previously met both ceilings.

Public health legislation ensured no out-of-pocket costs for COVID-19 tests and care

According to the Act on the Control of Communicable Diseases, all legal residents and visitors are exempt from cost-sharing for tests, health visits and treatment for infectious diseases deemed to pose a public health threat. COVID-19 was added to this list in January 2020, approximately a month before the first case had been detected. Testing remains free in public facilities, but private vendors offer same-day testing and fit-to-fly certificates for a fee.

Figure 14. Dental care and pharmaceuticals make up nearly half of out-of-pocket spending



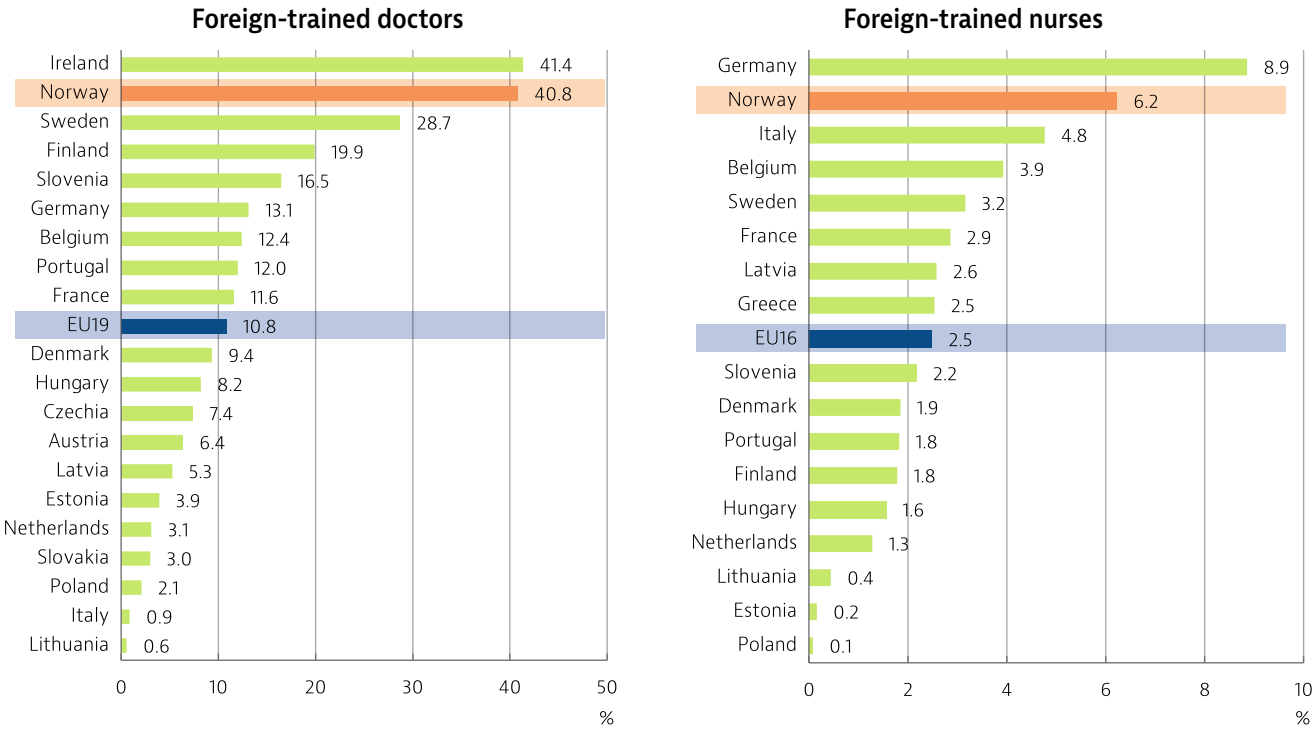
Note: The EU average is weighted. VHI = voluntary health insurance, which includes other voluntary prepayment schemes.
Sources: OECD Health Statistics 2021; Eurostat Database (data refer to 2019).

The health workforce relies heavily on foreign-trained doctors and nurses

Norway has one of the highest numbers of doctors and nurses relative to population size (see Section 4), but relies heavily on a foreign-trained health workforce. In 2020, 6 % of nurses and 41 % of doctors practising in Norway received their medical education abroad – much higher proportions than those observed in most EU countries (Figure 15). More than half (55 %) of foreign-trained doctors are Norwegian citizens returning to their home country following their education, with Poland, Hungary and Slovakia the most popular study destinations. Only four Norwegian universities are currently accredited to provide medical education, and the number of training slots is capped annually by the government.

A special commission appointed by the Ministry of Education and Research in 2019 recommended that Norway increase the number of training slots for medical doctors by 69 % by 2027 to ensure that 80 % of doctors are trained domestically (Grimstad Commission, 2019). This resulted in a 13 % increase in the number of domestic medical training slots introduced in autumn 2020. An inter-departmental working group is evaluating how to further expand medical training capacity.

Figure 15. Norway has large shares of foreign-trained doctors and nurses



Note: In Germany, data on foreign-trained doctors and nurses are based on nationality (not place of training).
Source: OECD Health Statistics 2021 (data refer to 2019 or the nearest year).

Reducing waiting times is a policy priority, but COVID-19 introduced further delays to care

Norway's Patients' Rights Act, first introduced in 1999, specifies that patients have the right to receive care within specific timeframes. Maximum waiting time targets apply to nationally covered services including GP visits, hospital care, mental health and substance abuse treatments. For specialist care, patients receive an individually assessed deadline, based on clinical severity. Patients can choose their treatment location nationally and receive reimbursement for travel costs. Information on hospital waiting times is available online. If a patient is not offered treatment within a "medically justifiable period of time", they can also apply to have their treatment in another EEA or EU country. Waiting times for elective surgeries such as cataracts and hip and knee replacements, as well as specialist services, are longer in Norway than in many European countries (OECD, 2020). One contributing factor may be that Norway has a relatively low supply of specialist physicians, including surgical specialists.

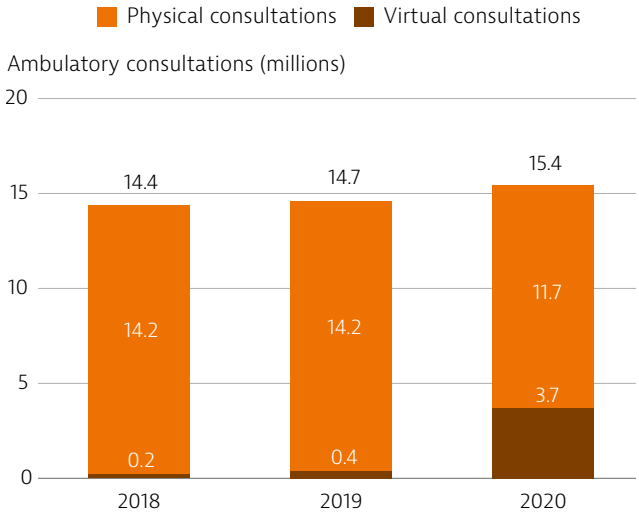
The COVID-19 pandemic necessitated a reorganisation of health care priorities. The national waiting time guarantee was suspended at the end of March 2020, and elective operations were postponed. In 2020, 7.3 % of patients did not receive hospital-based services within their individually set maximum waiting time, compared to just 2.4 % in 2019. Average waiting times for hospital-based specialist services also increased, from 61 days in 2019 to 65 days in 2020 (Directorate of Health, 2021). The national waiting time guarantee was reinstated in October 2020. The Norwegian Minister of Health and Care Services set a goal for all regions to reduce average waiting times for hospital-based health care to no more than 50 days in 2021.

Quick deployment of telehealth minimised disruptions to ambulatory care during the pandemic

In early March 2020 the Norwegian government instructed health care providers to prioritise acute care and cancer treatments, but to postpone elective care during the pandemic. In mid-April 2020, hospitals were advised to start reopening for elective care. While considerable reductions in the use of health care services were observed during March and April, most hospital services had returned to near-normal levels by the summer. The volume of specialist consultations was 9 % lower during the first eight months of the year relative to 2019 (Coronavirus Commission, 2021).

Telehealth played a large role in maintaining access to ambulatory care. Health care providers were instructed to switch to teleconsultations (video, phone or digital message including text messages and chats) on 17 March 2020, with reimbursement rates increased to equal those for in-person consultations. The proportion of ambulatory consultations conducted remotely rose from 3 % in early 2020 to 41 % during the peak of the first wave. Overall, the rise in digital consultations contributed to the total number of ambulatory consultations (in-person and digital) being slightly higher than in previous year (Figure 16). The Prime Minister set a goal for hospitals to conduct at least 15 % of specialist consultations digitally in 2021.

Figure 16. Digital consultations contributed to a higher number of GP consultations in 2020



Note: Data refer to the number of ambulatory consultations in millions; totals are shown on top of bars in black. Digital consultations refer to phone calls and text (SMS) and video communication.
Source: Data from the Control and Payment of Health Reimbursements registry, as reported by the eHealth Directorate (2021).

5.3 Resilience

This section on resilience focuses mainly on the impacts of and responses to the COVID-19 pandemic[2]. As noted in Section 2, the COVID-19 pandemic had a much smaller impact on mortality in Norway compared to most EU countries. The measures taken to contain the pandemic led to a contraction of the economy, especially during spring 2020. GDP fell by 2.5 % in 2020. This fall was considerably less than in many European countries.

A national lockdown curbed the first wave, but measures were less restrictive during the second wave

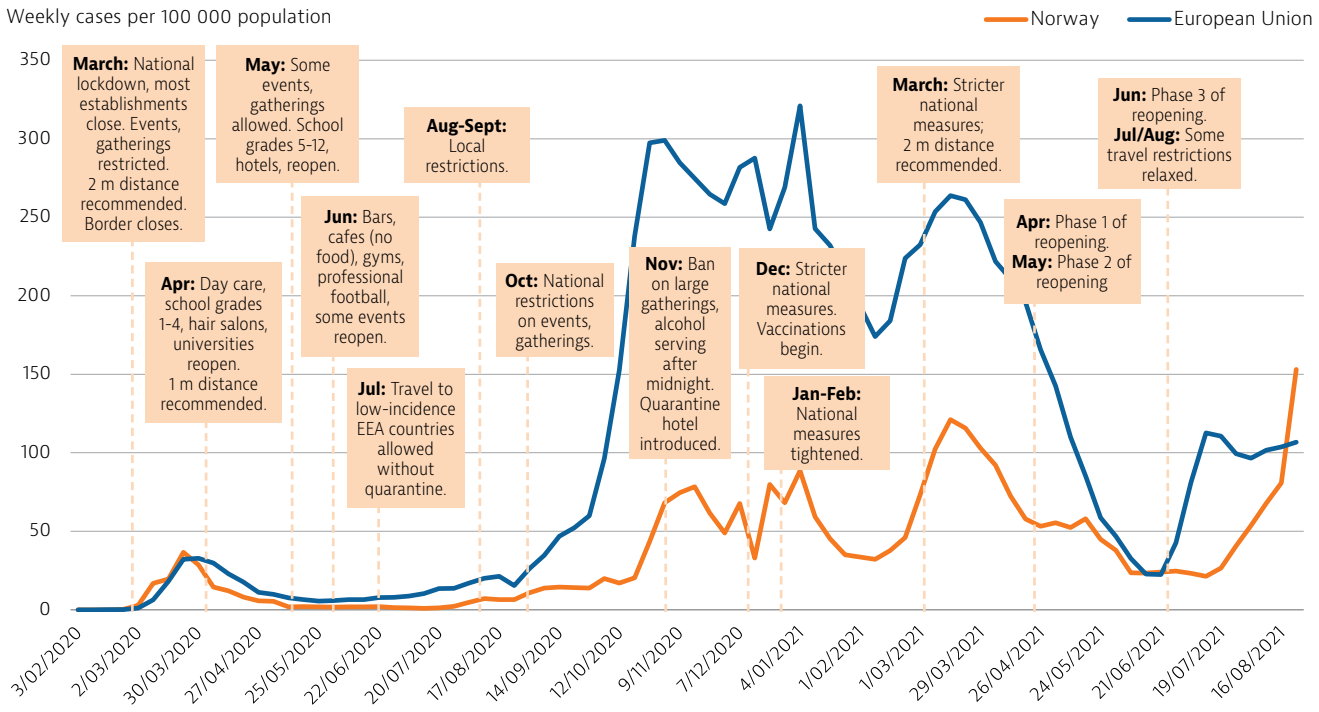
The first case of COVID-19 in Norway was identified on 26 February 2020. A national lockdown was announced on 12 March, which closed most public life (Figure 17). Social distancing and working from home were recommended, and large events were banned. Collectively, these represented the most sweeping measures the country had seen during peacetime.

As cases and hospitalisations started to decline, Norway started reopening society gradually in early April. Case rates continued to decline towards the summer, but increased again in August 2020, after travel to EEA countries with low infection rates was allowed in July.

This was accompanied by local restrictions in municipalities with local outbreaks. National measures were introduced in late October, following a steep rise in cases and hospitalisations, and later expanded in January 2021. Stricter national measures were implemented following outbreaks of highly contagious novel strains in March, which overwhelmed hospitals. Step-wise reopening of society started in mid-April 2021. At the end of September 2021, the Norwegian government announced the end of all national restrictions, apart from quarantine for infected individuals, marking the start of the 'A normal everyday life with increased emergency preparedness' phase.

Throughout the pandemic, case rates in Norway mostly remained below those across the EU. By the end of June 2021, 2.5 % of the population had been diagnosed with COVID-19 – a rate considerably lower than the EU average (8.2 %). Total infection and death rates were lower than in Denmark and Sweden, but similar to those in Finland. While incidence rates were higher during the second wave, death rates were lower. Individuals with migrant backgrounds were disproportionately affected (Indseth et al., 2021), prompting outreach efforts. Government allocations for outreach activities among migrant populations were increased from NOK 26.6 million (EUR 2.5 million) in 2020 to NOK 40 million (EUR 3.8 million) in 2021.

Figure 17. The first wave was curbed with a lockdown, but caseloads were higher in the second wave



Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Source: ECDC for COVID-19 data and authors for containment measures.

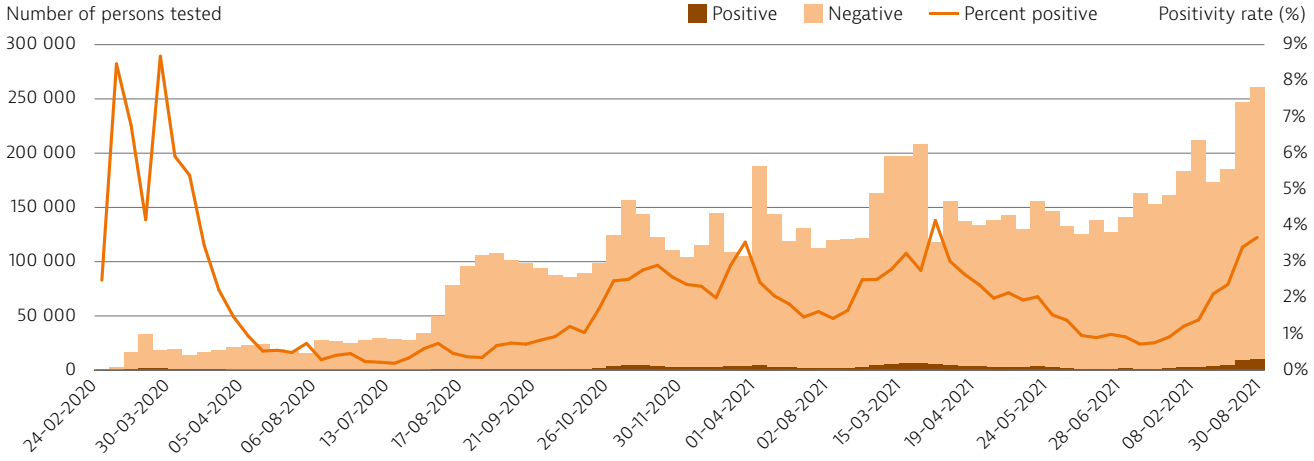
2. In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020)

Testing rates increased during autumn 2020 after eligibility rules were relaxed

The FHI coordinates preparedness for laboratory capacity and serves as the reference laboratory, while municipalities are responsible for organising testing sites. In April 2020, the government started preparing for large-scale population testing to facilitate a reopening of society. National testing capacity expanded from about 30 000 weekly tests to 300 000 weekly tests by the end of May 2020.

Testing was initially reserved for people with acute symptoms or confirmed exposure, but was gradually expanded to all symptomatic individuals (June), and then to anyone with potential exposure (August). This contributed to a rise in testing volumes (Figure 18). Test positivity rates peaked at around 8-9 % during the first wave and at around 3-4 % during the second.

Figure 18. Rates of testing increased dramatically ahead of the second wave



Source: FHI.

Contact tracing was supported by a mobile app that was redesigned at the end of 2020

Municipalities are responsible for contact tracing and supplying isolation facilities for those not able to isolate at home. People who have tested positive are required to provide information on close contacts but cannot be prosecuted for refusing to do so. Norway was early to launch a contact tracing mobile application, "Smittestopp", in mid-April 2020. Within two days of its launch, 1.2 million users had downloaded it (potentially 22 % of the population in Norway).

However, following concerns about privacy issues, the app was deleted in mid-June 2020. FHI rebuilt the app based on the Apple-Google framework used by contact tracing apps in most other European countries, which better addresses privacy concerns. Following its launch in December 2020, the new app had been downloaded 833 500 times, potentially reaching 15 % of the population. As of the end of June 2021, the app had slightly more than a million downloads, potentially representing 19 % of the population. In February 2021, the app was connected to other infection apps in Europe through the European Federation Gateway Service.

Travel quarantine requirements caused some controversy

Contact tracing of air travellers (international and domestic) was reintroduced in June 2020 after travel restrictions were relaxed, although the travel quarantine requirement was removed for those returning from low-incidence countries.

Testing at airports and border crossings was introduced in late autumn 2020. These became mandatory for travellers from high-incidence areas in November 2020, and for all passengers in January 2021.

Controversy was sparked in November 2020, when the government introduced a mandate for incoming travellers to quarantine in designated travel hotels at a cost of NOK 1 500 (EUR 143) per night for 10 days. After a public outcry, the cost was reduced to NOK 500 (EUR 48) per night in December, and home quarantine was allowed in some cases. Permanent residents were exempt until February 2021, after which rules were tightened. Since May 2021, quarantine hotel remains mandatory for individuals returning from areas with high infection rates within EEA/Schengen countries and the United Kingdom, as well as all non-EEA/Schengen countries.

Fully vaccinated individuals and those who have recovered from COVID-19 during the past six months were exempted from travel quarantine from mid-June 2021.

Mask-wearing was not common initially, but it was recommended during the second wave

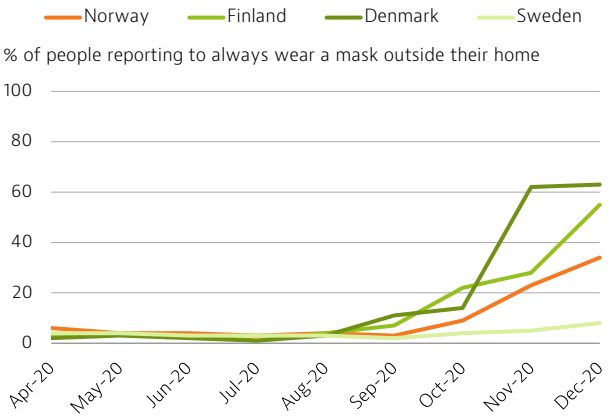
Face masks were uncommon in Norway during the first few months of the pandemic, with only between 3 % and 6 % of the population wearing them (Figure 19). The government started recommending use of face masks on public transportation in areas with high infection rates in August-September 2020. In October, the government recommended that municipalities with high infection levels should require face masks on public transportation and in indoor public spaces such as shops, restaurants and bars. This resulted in a rise in mask-wearing during autumn. By December 2020, one third (34 %) of Norwegians wore masks – a lower share than in Denmark and Finland. Widespread use of masks was recommended at the end of March 2021, when strict national measures were introduced to curb a rising second wave, in any situation where the newly-introduced 2-metre distance recommendation could not be adhered to.

National hospital bed and intensive care unit capacity were never exhausted

Norway had relatively low supplies of hospital and ICU beds before the pandemic (see Section 4). National preparedness plans state that RHAs are responsible for ensuring hospital capacity during national emergencies. According to the plans, the supply of ICU capacity could be increased from 289 to 925 beds, but based on FHI projections of prevalence during the peak of the pandemic (which estimated a need for 600-1 200 ICU beds), RHAs were requested to prepare to increase capacity to around 1 200 beds.

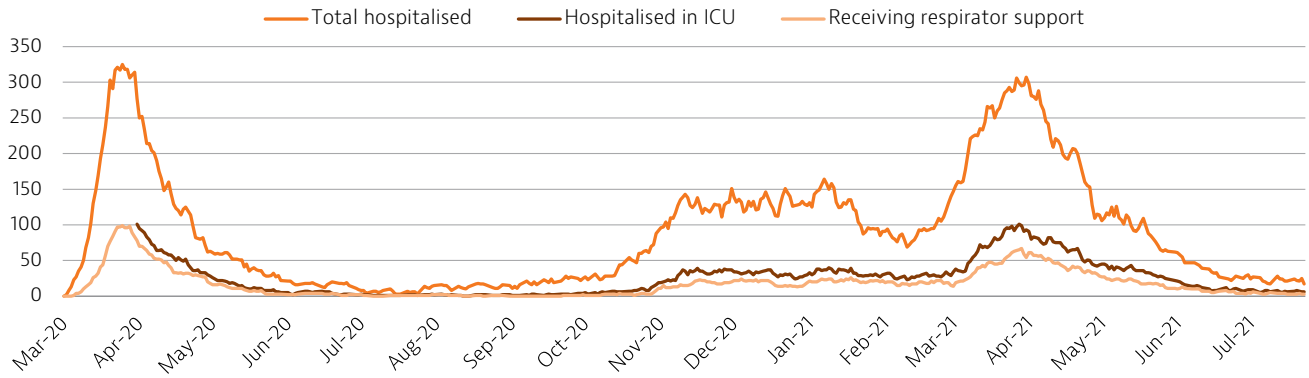
Additional ventilators, medical technical equipment and personal protective equipment (PPE) were purchased, and a comprehensive internal training programme for ICU treatment of COVID-19 patients was developed. Even at the heights of the first wave in April 2020 and the second wave in April 2021, however, only a maximum of around 2 % of the total national hospital bed capacity and around one third of existing (non-surge) ICU bed capacity was ever used (Figure 20). The second wave saw hospitals in some regions – particularly the capital region – stretched to capacity. This was managed in part by transferring elective postoperative patients to other nearby hospitals.

Figure 19. Mask-wearing outside the home increased after September 2020



Source: YouGov data (http://www.coviddatahub.com/).

Figure 20. Peak COVID-19 hospital and intensive care admissions were similar during the first and second waves



Note: Hospitalisations refer to patients with confirmed COVID-19 infection.
Source: Directorate of Health (2021) (data for 8 March 2020 to 23 July 2021).

Nursing home residents were protected by visit bans

The FHI first published recommendations on preventive measures in long-term care facilities on 29 February 2020. The advice was to treat infected residents on site as far as possible, to avoid hospitalisations. A ban on nursing home visits applied from 12 March to 27 May. Some nursing homes instituted bans on working in multiple sites at the same time to reduce the risk of contagion. In February 2021, restrictions on nursing home visits were relaxed, since the majority of nursing home residents had been fully vaccinated.

While exact figures are not available, an estimated half of all COVID-19 deaths in 2020 were in nursing homes. Overall, 3 % of all nursing home residents were infected in 2020, and 1 % died from COVID-19 (Coronavirus Commission, 2021).

Health workforce expansions were necessary

Despite Norway's large supply of doctors and nurses (see Section 4), workforce shortages limited the ability of hospitals to provide intensive care during the pandemic (Coronavirus Commission, 2021). On 24 March 2020, the Directorate of Health launched an official call for health workers not practising at the time to report for duty. Around 4 000 health workers signed up in the first two weeks; by May, nearly 6 500 personnel had done so. In April 2020, overtime compensation for health workers was increased. The existing workforce was also reallocated to provide COVID-19 care, and some personnel were retrained in intensive care provision and infection control. Medical and nursing students were also engaged, and rules for health care workers with foreign qualifications were relaxed in December 2020.

Shortages of personal protective equipment and medicines necessitated centralised solutions

According to the National Preparedness Plan against Pandemic Influenza, the Directorate of Health is responsible for ensuring the supply of pharmaceuticals and PPE, and for coordinating with the Norwegian Medicines Agency, FHI, RHAs and municipalities. Early in the pandemic, PPE shortages caused delays in testing, and the government appealed to dentists, veterinarians and private industry for donations. PPE exports were also restricted, and import tariffs were reduced. A purchasing deal with the People's Republic of China ensured excess national capacity of PPE between March and July 2020 (Coronavirus Commission, 2021). In March, a centralised system was developed for reporting remaining stocks, as well as procuring, storing and distributing PPE across the health sector.

The pandemic also led to medicines shortages. Supply of several essential medicines was rationed, and their export was banned. The Norwegian Medicines Agency also allowed the sale of generics medicines not originally intended for the Norwegian market (lacking labelling and patient information leaflets in Norwegian), and increased generics prices by 15 % between May and August 2020. In May, RHAs were tasked with establishing an emergency stockpile of pharmaceuticals, which was never depleted. The overall number of medicine shortages reported in 2020 was 11 % higher than in 2019, despite a near doubling observed in previous years.

The government took remedial action to strengthen emergency preparedness for future pandemics

The National Health and Hospital Plan 2020-23, originally presented in December 2019, was amended in May 2020 with provisions to support national production of pharmaceuticals and PPE, and to strengthen access to intensive care and emergency transport in remote parts of the country. The government also increased the number of training slots available for physicians starting in autumn 2020 and for intensive care nurses starting in 2021.

The national vaccine strategy was adjusted several times

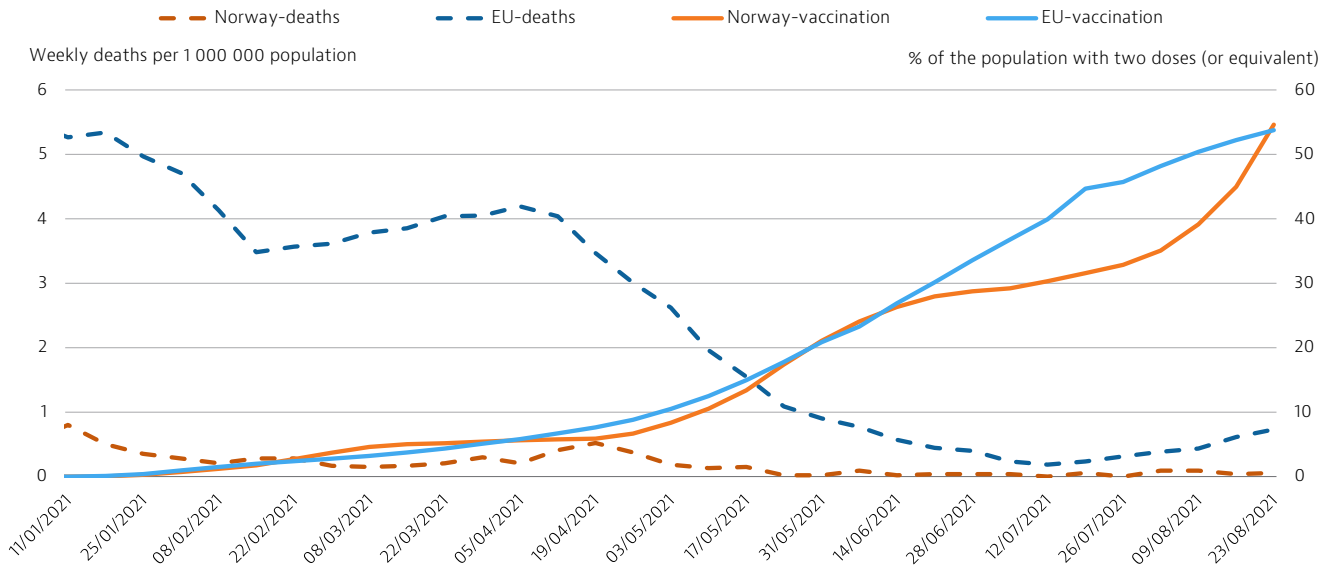
Vaccinations started at the end of December 2020. National guidelines prioritised nursing home residents, older adults and individuals in risk groups – including people with underlying chronic conditions – and health care professionals. Municipalities organised vaccination administration, with vaccines distributed according to the share of residents in older age groups, while the Directorate of Health supplied needles and syringes. As the COVID-19 vaccine is part of the national immunisation programme, it is free of charge to patients.

Norway paused use of the AstraZeneca and Janssen vaccines in March 2021, following reports of rare but serious adverse side effects. A government-appointed expert task force conducted a risk/benefit assessment and recommended the removal of viral vector vaccines from the national COVID-19 immunisation programme. People who had received an AstraZeneca vaccine were offered an mRNA-based second dose. The Janssen vaccine remains available for some individuals following a recommendation by their GP, outside the national programme.

The time interval between first and second doses of mRNA vaccines (BioNTech and Pfizer, Moderna) was increased twice – to 6 weeks in March and to 12 weeks in May – to facilitate vaccinating more people in priority groups with their first dose. The national strategy was also adjusted to allocate larger shares of vaccines to municipalities with high infection rates.

By the end of August 2021, 55 % of the population had received two doses or the equivalent (Figure 21). The vast majority (93 %) of adults aged 85 and over, and 90 % of front-line health and social services workers, had received at least one dose. COVID-19 certificates were rolled out in June 2021, when Norway also connected to the EU's Digital COVID Certificate.

Figure 21. The population vaccinated against COVID-19 in August 2021 was close to the EU average



Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Source: ECDC for COVID-19 deaths and Our World in Data for vaccination rates.

Norwegian health information systems allowed a real-time overview of the development of the pandemic

All COVID-19 cases are notifiable to the national Notice System for Infectious Diseases. In April 2020, a new registry (BeredtC19) was established; this combines data from several national registries, including the Notice System. It provides a real-time overview of COVID-19 infections, hospitalisations and mortality, and facilitates analyses of contributing risk factors and consequences of COVID-19 infections. The ability to link national health datasets from across the health sector for monitoring and research purposes sets Norway apart from many other European countries. The FHI publishes weekly situation updates based on this data.

An independent commission evaluated Norway's response in the pandemic's first year

The government appointed an independent Coronavirus Commission in April 2020 to evaluate the government's response to COVID-19 until March 2021. The resulting report released a year later concluded that authorities had handled the pandemic well overall, but noted shortcomings in PPE procurement, communication with immigrant populations, speed of implementing containment measures and communication with municipalities, among others (Coronavirus Commission, 2021). The relative success of Norway's handling of the pandemic during the first year has been attributed to geographical factors (including its location at the outskirts of Europe and low population density), high levels of trust in the government, good collaboration between levels of government, political consensus on containment measures and a highly digitalised society. Generous social welfare arrangements, such as paid sick leave and unemployment arrangements, also helped people to stay at home (Coronavirus Commission, 2021; OECD/EU, 2020).

6 Key findings

- Life expectancy in Norway is the highest in Europe, at 83.3 years in 2020. Norway is one of just three European countries where life expectancy increased in 2020 – by 0.3 years, despite the COVID-19 pandemic. Overall, COVID-19 death rates in 2020 were nearly nine times lower than the EU average, and no excess mortality was observed.

- Norway's spending on health is the highest in Europe in per capita terms, although when measured as a share of GDP it is comparable to the EU average. Public spending represents 86 % of health expenditure – the highest share in Europe. Norway also devotes more spending to long-term care than any EU country.

- The health care system provides universal access to a broad benefits package. Annual cost-sharing ceilings protect patients from high health spending, and these were lowered and simplified in 2021. Cost-sharing exemptions apply for priority services and vulnerable populations. Unmet needs for medical care are low, mainly related to waiting times, while unmet needs for dental care are higher.

- Reflecting good access to effective treatment, Norway has one of the lowest rates of deaths from treatable causes in Europe, and high cancer survival rates. Standardised patient care pathways help reduce geographical variation in care quality. Rates of preventable deaths are also low, reflecting strong primary care and relatively healthy lifestyles: both smoking rates and alcohol use are lower than in the EU overall. Increasing overweight, physical inactivity and the use of snus (a smokeless oral tobacco product) among adolescents are areas for improvement, however.

- Norway has a good supply of doctors and nurses, with high reliance on a foreign-trained workforce. The National Health and Hospital Plan 2020-23 launched 19 health care communities, which are tasked with coordinating planning, priority-setting and service provision across sectors.

- The first wave of COVID-19 cases was curbed through a national lockdown introduced in mid-March 2020. Norway was one of the first countries to start gradually reopening society in April, with no rise in cases observed until late summer. The second wave saw less restrictive containment measures, although a rise in cases in March 2021 necessitated national restrictions. In contrast to most EU countries, death rates were lower during the second wave than during the first.

- Testing rates were higher than the EU average during the second wave, and expanded testing capacity contributed to low positivity rates. Norway's original contact tracing mobile app was redesigned following privacy concerns and was relaunched in December 2020. In June, the app was connected to the European Federation Gateway Service. The Norwegian Public Health Institute was able to monitor and report on the epidemiological situation in real time, thanks to existing registries.

- The health system remained relatively flexible throughout the pandemic. Hospital and intensive care unit capacity was never exhausted, but workforce expansions were necessary. Shortages of personal protective equipment and medicines at the beginning of the pandemic led to centralised purchasing and distribution solutions. Rapid expansion of telehealth ensured continuity of ambulatory care, but delays were observed for specialist hospital care and some cancer screenings.

- The relative success of Norway's handling of the pandemic during the first year has been attributed to factors such as rapidly implemented containment measures, geographical location, low population density, high levels of trust in government and generous social welfare arrangements.

Key sources

OECD/EU (2020), *Health at a Glance: Europe 2020. State of Health in the EU Cycle.* Paris, OECD Publishing, https://doi.org/10.1787/82129230-en.

Saunes IS et al. (2021), COVID19-Health System Response Monitor: Norway. WHO Regional Office for Europe, European Commission, and European Observatory on Health Systems and Policies. https://www.covid19healthsystem.org/mainpage.aspx

References

Cancer Registry of Norway (2021). *Cancer in Norway 2020 - Cancer incidence, mortality, survival and prevalence in Norway.* Oslo: Cancer Registry of Norway, https://www.kreftregisteret.no/Generelt/Rapporter/Cancer-in-Norway/.

Coronavirus Commission (2021), *Myndighetenes håndtering av koronapandemien – Rapport fra Koronakommisjonen*. Norges Offentlige Utredninger, No. 2021:6.

Directorate of Health (2021), *Ventetider og pasientrettigheter*

eHealth Directorate (2021), *Utviklingstrekk 2021: E-helsetrender*

EU Expert Group on Health Systems Performance Assessment (HSPA) (2020), *Assessing the resilience of health systems in Europe: an overview of the theory, current practice and strategies for improvement*

European Commission (2021), *Europe's Beating Cancer Plan*

FHI (2020a), *Foreløpige tall for dødsårsaker i perioden mars–mai 2020*, Norwegian Public Health Institute

FHI (2020b). *Utbredelse av snusbruk i Norge.* Norwegian Public Health Institute

Grimstad Commission (2019), *Studieplasser I Medisin I Norge: Behov, modeller og muligheter,* Ministry of Education and Research

Indseth T et al. (2021), *COVID-19 among persons born outside Norway, adjusted for occupation, household crowding, medical risk group, education and income,* Norwegian Public Health Institute

Larønningen S et al. (2021), *Kreftdiagnostikk under Covid-19,* Norwegian Cancer Registry

Monsrud, M (2021). *Lav vekst i helseutgiftene i 2020*, Statistics Norway.

Nilssen Y et al. (2020), *Patient and tumour characteristics associated with inclusion in cancer patient pathways in Norway in 2015-2016*. BMC Cancer, 20(1):488.

OECD (2020), *Waiting times for health services: next in line,* OECD Health Policy Studies.

SKDE (2020), *Sørge-for-ansvaret under koronapandemien*, Centre for Clinical Documentation and Evaluation.

Statistics Norway (2021), *Ingen overdødelighet i 2020*

Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

European Commission

State of Health in the EU
Country Health Profile 2021

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, in cooperation with the European Commission.

The concise, policy-relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

- health status in the country
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: ec.europa.eu/health/state

Please cite this publication as: OECD/European Observatory on Health Systems and Policies (2021), *Norway: Country Health Profile 2021, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

ISBN 9789264409156 (PDF)
Series: State of Health in the EU
SSN 25227041 (online)

OECD
BETTER POLICIES FOR BETTER LIVES

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