European Commission



State of Health in the EU

Norway

Country Health Profile 2023

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European Observatory on Health Systems and Policies
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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 policy makers and influencers with a means for mutual learning and voluntary exchange. For the first time since the series began, the 2023 edition of the Country Health Profiles introduces a special section dedicated to mental health.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation 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).

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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 finalised in September 2023, based on data that were accessible as of the first half of September 2023.

Demographic and socioeconomic context in Norway, 2022

Demographic factors	Norway	EU
Population size	5 425 270	446 735 291
Share of population over age 65 (%)	18.2	21.1
Fertility rate[1] (2021)	1.6	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	74 760	35 219
Relative poverty rate[3] (%, 2020)	12.7	16.5
Unemployment rate (%)	3.2	6.2

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.

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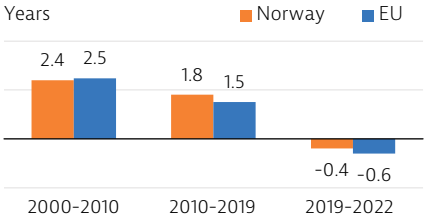
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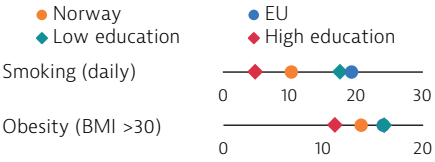
1 Highlights



Changes in life expectancy at birth

Health Status

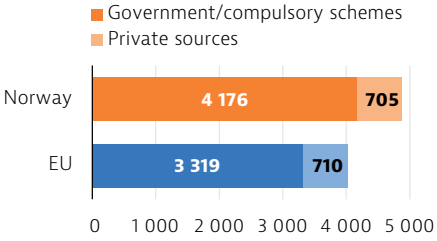
Norway's life expectancy grew by over 4 years in the two decades before the COVID-19 pandemic, increasing at a rate comparable to the EU average. It reached 83.2 years in 2021, which was one of the highest levels in Europe and 0.2 years higher than its pre-pandemic level. However, following a relatively large surge in COVID-19 deaths, life expectancy fell to 82.6 years in 2022.



% of population aged 15+

Risk Factors

As in most EU countries, prevalence of behavioural risk factors in Norway tends to follow a socioeconomic gradient. In 2019, smoking was three times more common among individuals in the lowest income quintile than those in the highest. Obesity showed a similar, albeit less pronounced, pattern.



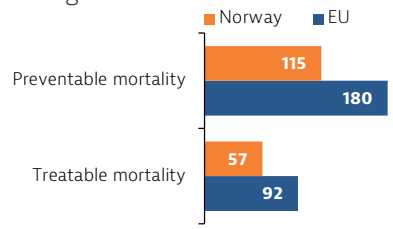
EUR PPP per capita, 2021

Health System

In 2021, Norway's per capita health spending exceeded the EU average by more than 20 %, although it was 1 percentage point below the EU average when measured as a share of GDP. Over 85 % of health spending was publicly funded, which is one of the highest proportions in Europe. Norway's spending allocated to long-term care – both on a per capita basis and as a proportion of total health expenditure – was the highest in Europe.

Effectiveness

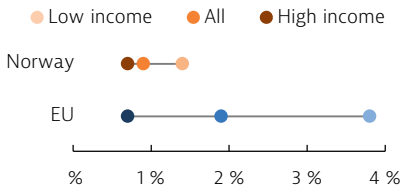
In 2020, Norway's mortality rate from preventable and treatable causes combined was over a third lower than the EU average. While the EU saw a 17 % rise in preventable mortality in 2020 due to COVID-19 deaths, Norway's rate continued to decline slightly, and the country's treatable mortality rate fell by 3.2 % per year from 2011 to 2020 – more than twice the EU average decline.



Age-standardised mortality rate per 100 000 population, 2020

Accessibility

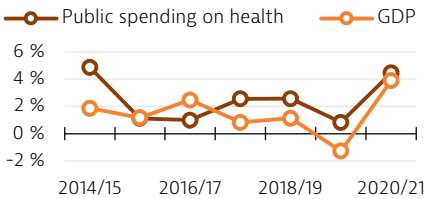
Fewer than 1 % of Norwegians reported experiencing unmet medical care needs in 2020 – the lowest rate among Nordic countries. Excessive waiting lists were the main driver of unmet medical needs. Norwegians in the lowest income quintile were twice as likely to report unmet needs as those in the highest quintile – a smaller gap than in other Nordic countries.



% reporting unmet medical care needs, 2022

Resilience

In the five years before the pandemic, government health spending grew by 2.3 % per year, slightly outpacing GDP growth until 2019. The pandemic did not significantly disrupt this pattern, as spending increased by less than 1 % while GDP fell by 1.3 % in 2020. In 2021, government health spending increased by over 4 % in line with GDP, propelled mostly by COVID-19-related spending.



Annual change in real terms

Mental Health

Mental health issues carry a substantial burden in Norway: nearly 18 % of Norwegians had a mental health disorder in 2019, and mental health and substance-use disorders collectively accounted for one fifth of total health spending. As in other countries, depression was more commonly reported among women and people on lower incomes. In contrast to other Nordic countries, Norway's consumption of antidepressants did not increase significantly over the past decade. The COVID-19 pandemic has not caused a significant upsurge in the demand for mental health services.

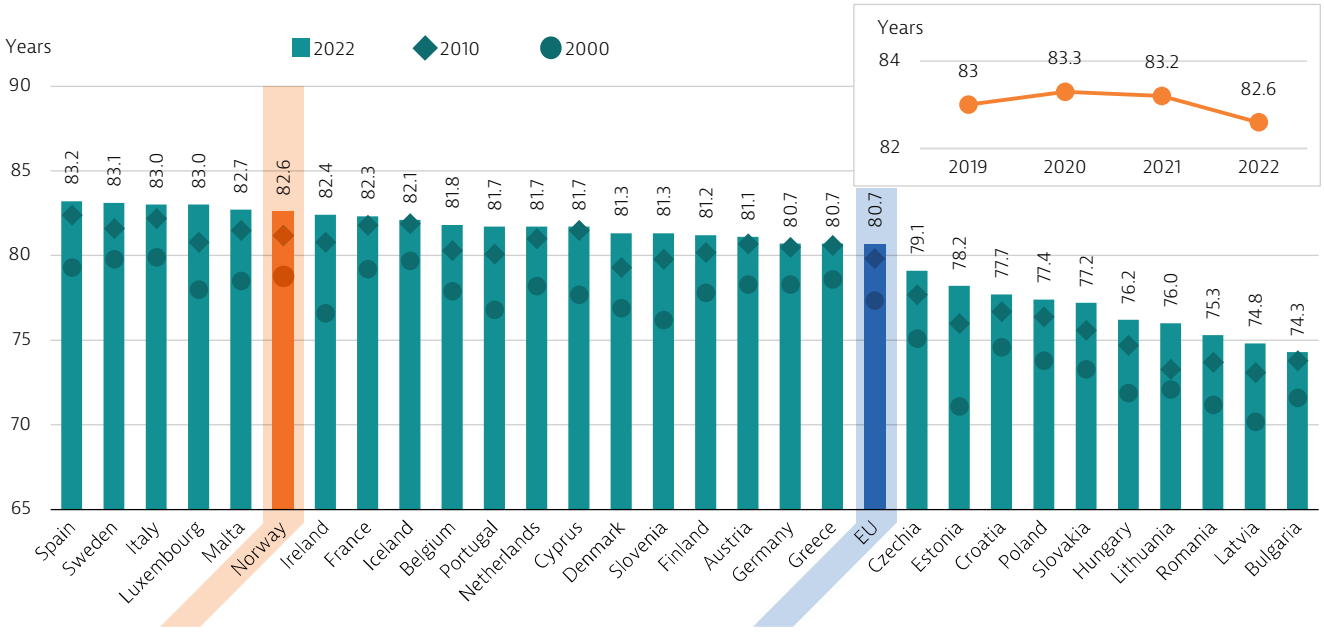
2 Health in Norway

Norway's life expectancy ranked among the highest in Europe in 2022

Norway's life expectancy at birth stood at 82.6 years in 2022, surpassing the EU average by almost two years (Figure 1). From 2010 to 2019, life expectancy increased at a slightly faster rate compared to the EU average. Following the onset of the COVID-19 pandemic, life expectancy increased by 0.3 years in 2020 and experienced a marginal decline of 0.1 years in 2021, reflecting the low mortality impact of the pandemic in the country. However, in 2022, a significant increase in COVID-19 deaths resulted in a decrease in life expectancy to nearly five months below its pre-pandemic level.

As in other European countries, there exists a gender disparity in life expectancy. In 2021, Norwegian women could expect to live, on average, three years longer than men. This gender gap in life expectancy was notably smaller than the EU average of 5.7 years.

Figure 1. Norway's life expectancy fell below the pre-pandemic baseline for the first time in 2022



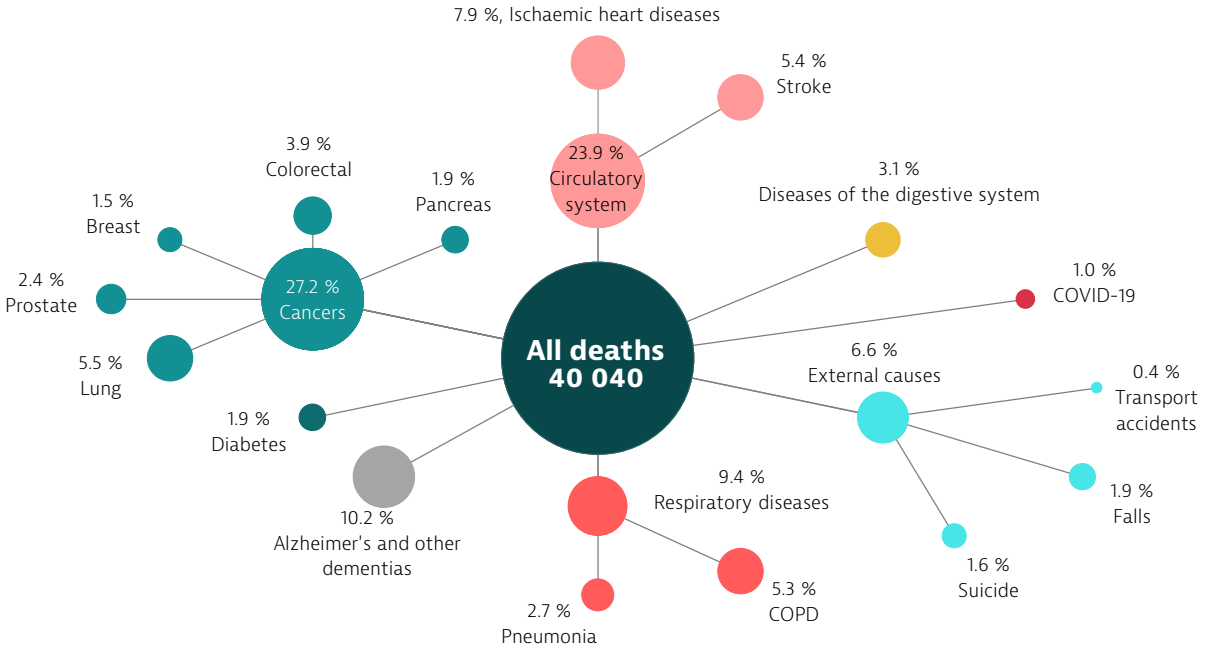
Notes: The EU average is weighted. The 2022 data are provisional estimates from Eurostat that may be different from national data and may be subject to revision. Data for Ireland refer to 2021.
Source: Eurostat Database.

Cancer and circulatory diseases are the main causes of death in Norway

Over the last decade, Norway's life expectancy gains can be attributed primarily to the reduction in mortality rates from circulatory diseases and, to a lesser extent, cancer. Circulatory diseases were the leading cause of death in Norway until 2017, when their decades-long decline resulted in them becoming the second most common cause of death after cancers. Cancer thus was the largest driver of mortality in Norway, accounting for more than 27 % of all fatalities in 2020 (Figure 2). Among cancers, lung cancer remains the most frequent cause of death, being responsible for one in every five cancer fatalities. Colorectal and breast cancer combined were responsible for another 20 % of cancer deaths. Circulatory diseases (23.9 % of all deaths) and respiratory diseases (9.4 %) were the second and third leading causes of mortality in 2020.

During the first year of the pandemic, COVID-19 accounted for 414 deaths or 1 % of all deaths in Norway (National Institute of Public Health, 2022) – a much lower share than the 8.5 % registered across the EU. Nearly half of them occurred in people aged 85 years and above – a share slightly above the EU average. However, the number of confirmed COVID-19 deaths surged to 864 in 2021 and rose further to 2 858 in 2022.

Figure 2. Cancer and circulatory diseases were the leading causes of death in Norway in 2020



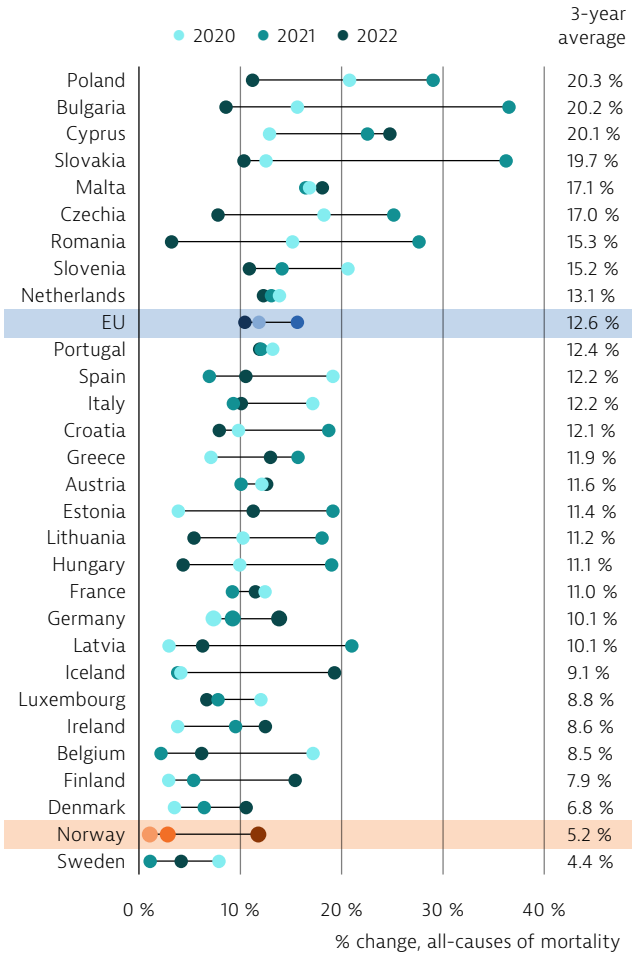
Note: COPD refers to chronic obstructive pulmonary disease.

Source: Eurostat Database (data refer to 2020).

The indicator of excess mortality, defined as deaths occurring (regardless of their cause) above a baseline derived from pre-pandemic levels, provides a more comprehensive picture of the pandemic's mortality impact. The approximately 6 400 excess deaths that occurred in Norway between 2020 and 2022 account for a level 5.2 % above the historic baseline – a much lower rate compared to the EU average and the second lowest excess mortality rate observed among Nordic countries after Sweden.

Throughout the pandemic, the pattern of excess deaths closely followed the trend of COVID-19 deaths in Norway. Over two thirds of both excess deaths and COVID-19 deaths were recorded in 2022. In that year, excess mortality peaked at nearly 12 % above its pre-pandemic baseline (Figure 3).

Figure 3. Norway experienced a significant surge in excess mortality only in 2022



Note: Excess mortality is defined as the number of deaths from all causes above the average annual number of deaths over the previous five years before the pandemic (2015-19).

Source: OECD Health Statistics based on Eurostat mortality data.

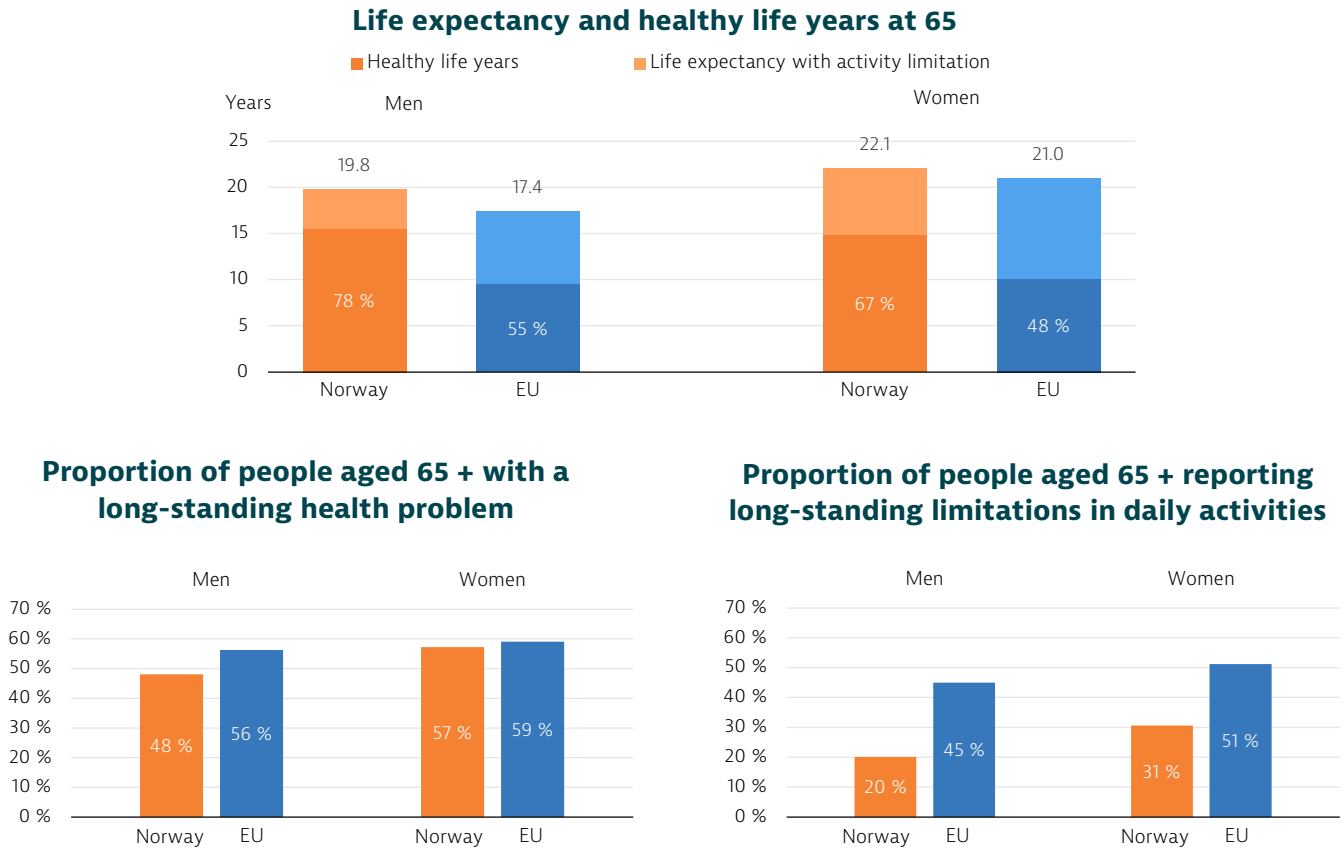
Women live a greater proportion of their lives after age 65 with disabilities

Despite being one of the youngest countries in Europe, Norway's elderly population is projected to grow significantly in the coming decades – a shift driven by higher life expectancy and a fertility rate below the replacement level. In 2022, 18 % of Norway's population was aged 65 and above, up from approximately 15 % in 2000. Projections indicate that this share will rise to 24 % by 2050.

As of 2020, women aged 65 could expect to live for another 22.1 years, while men could expect to have an additional 19.8 years ahead (Figure 4). For women, 67 % of this additional time was anticipated to be lived in good health, while for

men this proportion was 78 %. Both of these figures largely exceeded their respective EU averages – especially the one for men – resulting in a gender gap in healthy life expectancy at 65 of about 7 months in their favour. Compared to the EU average, a lower proportion of Norwegians aged 65 and over reported dealing with longstanding health problems, and an even lower proportion reported experiencing longstanding limitations in usual activities due to health problems, with fewer men than women reporting both.

Figure 4. Norwegians at age 65 can expect to live a much larger portion of their remaining life in good health compared to the EU average



Sources: Eurostat Database (for life expectancy and healthy life years) and EU-SILC (for longstanding health problems and limitations in daily activities). Data refer to 2020.

The burden of cancer in Norway is considerable

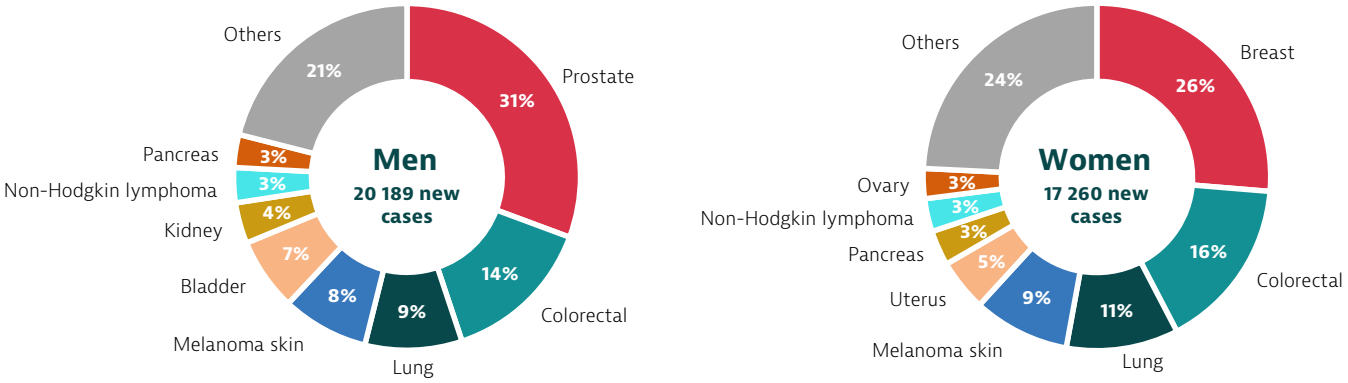
According to incidence estimates from the Joint Research Centre based on historical trends, Norway saw approximately 37 500 new cancer cases occur in 2022[1]. The incidence of cancer among Norwegian men was projected to be 28 % higher than that among women – a narrower gap relative to the EU average, reflecting a comparatively higher cancer incidence among Norwegian women. Over the last decade, Norway saw an average annual increase of 1.7 % in new cancer cases among women and 1.1 % among men, a rate consistent with trends in other Nordic countries. However, when controlling for population ageing, the annual increase in cancer incidence among women was less than 1 %, while among men it even declined by 0.5 % per year.

This reduction in cancer incidence growth can be attributed, in part, to decreased exposure to behavioural risk factors and improved diagnosis of cancer precursors (Cancer Registry of Norway, 2023).

Prostate cancer was projected to be the single most common cancer site among men, comprising over 30 % of all new cancers in 2022. For women, breast cancer was expected to account for over a fifth of all new cancer cases. Both among Norwegian men and women, colorectal and lung cancers were anticipated to be the second and third most frequent cancer sites (Figure 5). Approximately three quarters of new cases occurred in individuals aged 60 and older.

1 *According to estimates from the Cancer Registry of Norway (2023), 38 265 new cancer cases occurred in Norway in 2022. This figure is approximately 2 % higher than the estimated count by the Joint Research Centre.*

Figure 5. In 2022, most cancer cases emerged in the forms of prostate, breast and colorectal cancers



Age-standardised rate (all cancer): 829 per 100 000 population
EU average: 684 per 100 000 population

Age-standardised rate (all cancer): 647 per 100 000 population
EU average: 488 per 100 000 population

Notes: Non-melanoma skin cancer is excluded; uterus cancer does not include cancer of the cervix.
Source: ECIS – European Cancer Information System.

3 Risk factors

Behavioural risk factors contribute to a significant proportion of deaths in Norway

As in other European countries, behavioural risk factors have a significant impact on mortality in Norway. According to estimates by the Institute For Health Metrics and Evaluation (IHME), in 2019 behavioural risk factors were responsible for 29 % of all deaths in the country – a relatively low share compared to other European countries. Among them, dietary risks and tobacco use were the main contributors to deaths, being associated with 13 % and 12 % of all fatalities respectively (Figure 6). Alcohol consumption was estimated to contribute to 3 % of deaths – a much lower share compared to the EU average (6 %), while the share of total deaths associated with insufficient physical activity was on a par with the EU average at 2 %. Air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone accounted for 1 % of all deaths – approximately four times lower than the EU average.

Figure 6. Dietary risks and tobacco remain important contributors to overall mortality



Notes: 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 $PM_{2.5}$ and ozone.
Source: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Rates of obesity among adults are relatively low, but overweight and obesity among adolescents are on the rise

Nearly 14 % of adults in Norway were classified as obese in 2019, reflecting an increase from the 12.6 % observed in 2014, but still below the corresponding EU average of 16 %. More than two thirds of Norwegian adults reported engaging in a minimum of 150 minutes of moderate physical activity per week in 2019, a percentage higher than that seen in all EU countries. However, less than 9 % of Norwegians reported eating at least the recommended five portions of fruit and vegetables a day in 2019, a proportion below the EU average of 12.4 %. Similarly to adults, over 18 % of Norwegian 15-year-olds were classified as either overweight or obese in 2022. While this proportion was lower than the EU average of 21.2 %, it marked an increase from the 15.5 % reported in 2014.

Smoking rates are low, but snus remains a popular alternative among young adults

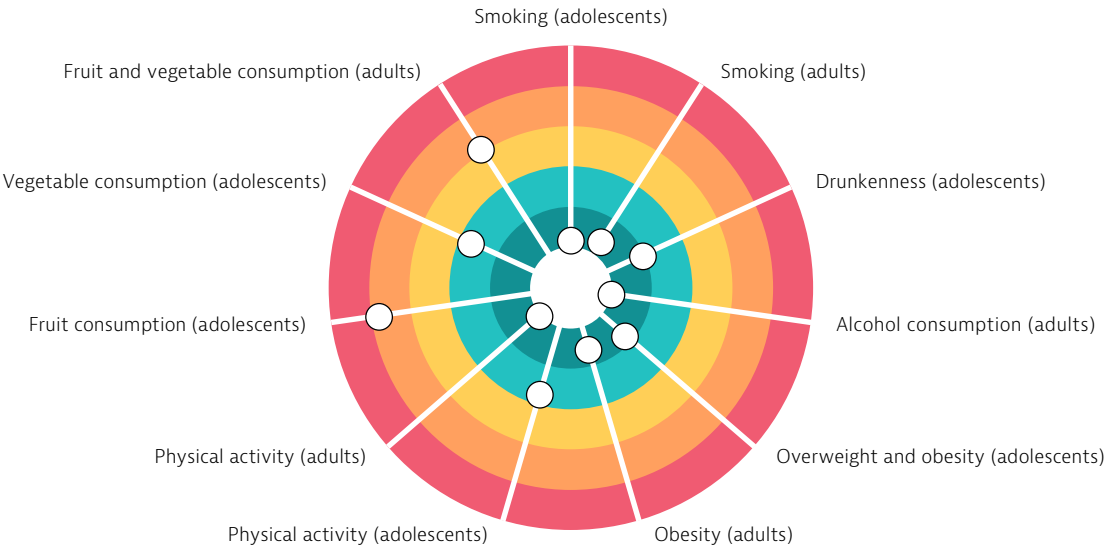
Norway boasts some of the lowest smoking rates in Europe. In 2019, only 9 % of adults reported daily tobacco consumption, a stark difference from the EU's nearly 20 % average. The prevalence of smoking in Norway continued to decrease during the pandemic, dropping to just 7 % in 2022. Among 15-year-olds, 9 % reported cigarette smoking in 2022 – a proportion in line with the 2014 figure. This rate is also notably lower than the EU average of 17 %.

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. However, the use of snus, an oral smokeless powdered tobacco product, has witnessed a notable surge over the past two decades, particularly among young individuals. In 2022, 15 % of women and 25 % of men aged 16-24 reported being daily snus consumers. This stands in stark contrast to the fewer than 1 % of women and 7 % of men who reported using snus in 2000 (National Institute of Public Health, 2023). The growing popularity of snus can be attributed to several factors, including its lower price compared to cigarettes (due to lower taxation), relatively high nicotine content, availability of various flavours and a range of packaging sizes.

Alcohol consumption levels are low

Alcohol consumption in Norway is among the lowest in Europe (Figure 7). In 2021, the average per capita consumption of pure alcohol was 7.4 litres, which is nearly one quarter lower than the EU average. Although consumption is comparatively low, however, it is worth noting that alcohol consumption among adult Norwegians has seen a significant increase since 2011, when it stood at 6.4 litres per capita. In contrast, a relatively low 14 % of Norwegian 15-year-olds reported having been drunk at least twice in their lifetime, a percentage lower than the EU average of 18 % which also marks a substantial decline from the 27 % reported in 2010.

Figure 7. Levels of fruit and vegetable consumption are relatively low in Norway



Notes: The closer the dot is to the centre, the better the country performs compared to other 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 2022 for adolescents indicators; and EHIS 2019 for adults indicators.

Several policies contribute to lower alcohol use in Norway compared to other European countries. Chief among these are alcohol prices, which are among the highest in Europe owing to high taxation. Access is controlled through Vinmonopolet, 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 for beer and cider in supermarkets, and a ban on selling alcohol at kiosks and gas stations. Additionally, Norway has imposed bans on alcohol advertising and the practice of happy hours in bars and restaurants.

4 The health system

Regions and municipalities play important roles in service provision, and concerted efforts are made to improve coordination between levels

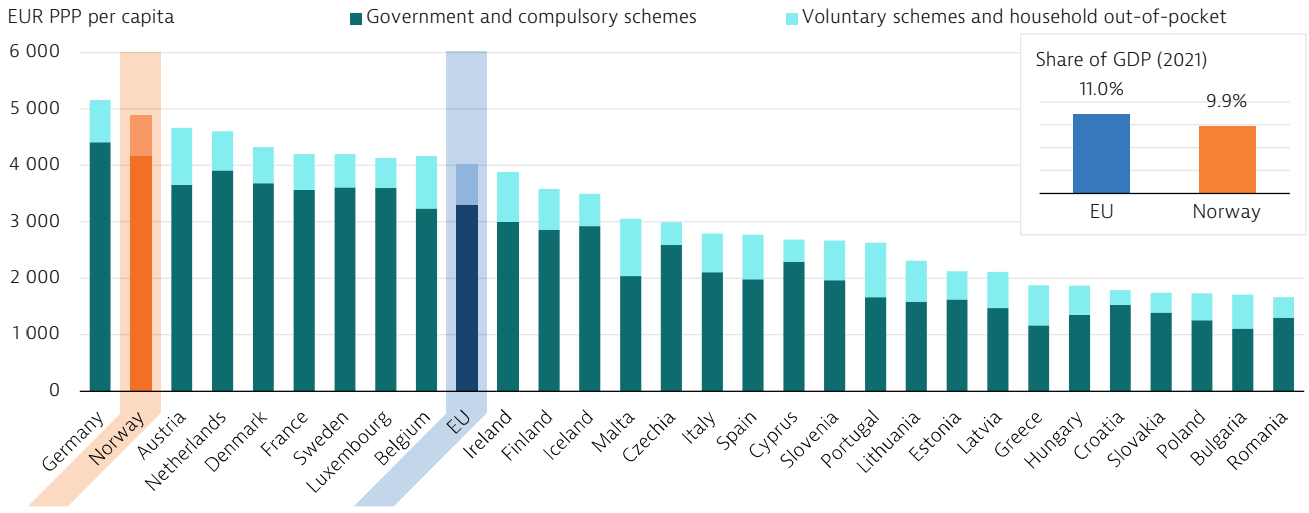
Norway provides universal health coverage to all legal residents. For undocumented migrants, only emergency acute care is covered for adults, while children also get access to basic services such as vaccinations and examinations. Statutory benefits are comprehensive, and cost-sharing is moderate, but access to some services such as dental care may be obstructed by copayment requirements (see Section 5.2).

The health system is partly decentralised. The Ministry of Health and Care Services, along with its subordinate agencies, is responsible for planning, regulating and supervising the healthcare system. Four regional health authorities (RHAs) are in charge of specialist care, which is provided in hospital trusts owned by the RHAs, including in polyclinics within hospital outpatient departments. The vast majority of Norwegian patients are treated in publicly funded hospitals. Since January 2023, patient choice of hospitals has been limited to public providers and private providers with a public tender agreement (Saunes, 2023a). Municipalities are responsible for the organisation of primary care, which is primarily delivered by independent general practitioners (GPs) who perform a gatekeeping function to specialist care.

Healthcare expenditure in Norway is high and mostly funded through public sources

In 2021, Norway's health expenditure per capita was among the highest in Europe, although it stood over one percentage point below the EU average when measured as a proportion of GDP (Figure 8). At EUR 4 881, Norway spent about 15 % more on healthcare in per capita terms than neighbouring countries Sweden and Denmark. The proportion of public financing for health was among Europe's highest at 86 % in 2021 and remained stable throughout the COVID-19 pandemic. Taxation revenue – especially national and municipal taxes – is the main source of financing. Copayments are applicable to various publicly funded health services, including primary care.

Figure 8. Norway spends almost a quarter more than the EU average on health



Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

From 2015 to 2019, Norway experienced an average annual real growth rate of 1 % in health spending per capita, mainly driven by increased government expenditure. In 2020, the country's health expenditure per capita saw a modest rise of only 0.2 % in real terms, reflecting the combined effect on expenditure of reduced outpatient and hospital activity throughout the year and the mild impact of COVID-19 in the country during the first year of the pandemic.

In 2021, health expenditure per capita witnessed a notable 4.1 % increase, driven in large part by more substantial public spending linked to COVID-19 (including testing and vaccines) as well as efforts to address patient backlogs accumulated in 2020. Private health expenditure also rose by 5.2 %, as non-COVID-19-related care volumes gradually resumed towards pre-pandemic levels.

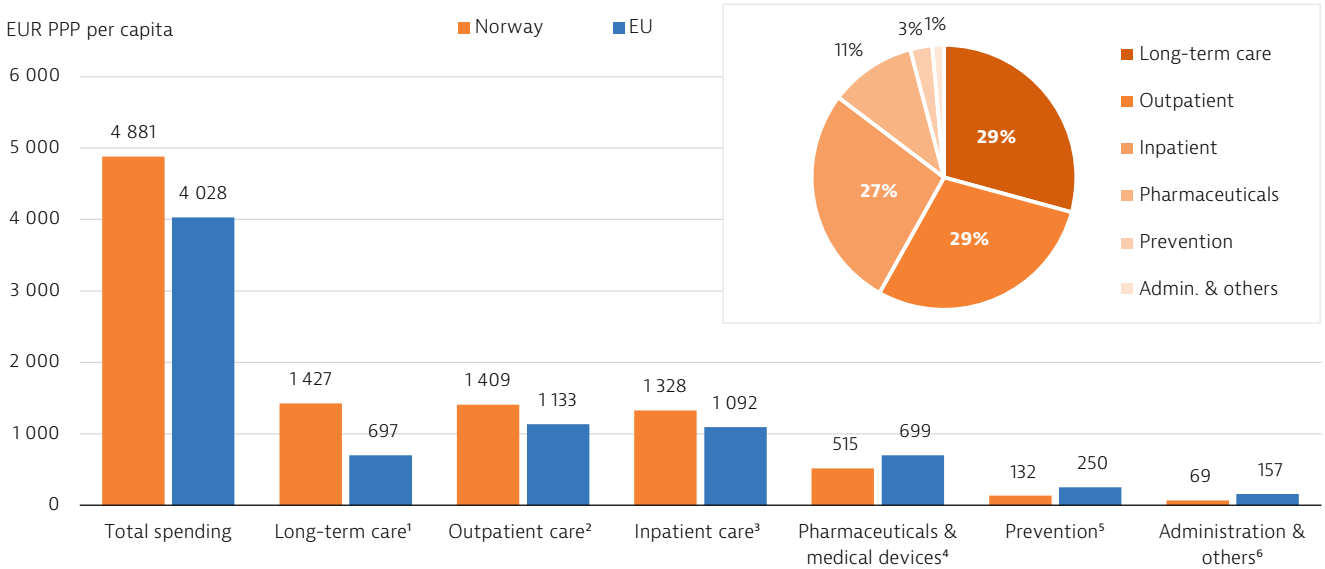
Health spending is distributed evenly among inpatient, outpatient and long-term care

In 2021, Norway allocated similar portions of its health budget on inpatient, outpatient and long-term care – slightly below 30 % for each category (Figure 9). Expenditure on long-term care was nearly double the EU average in both EUR per capita terms and as a proportion of the total health budget – a factor underscoring the government's significant commitment to supporting family caregivers' continued participation in the labour market. In contrast, Norway allocated less than 11 % of its health budget to retail pharmaceuticals and medical devices, marking one of the lowest shares in the EU. This reflects, in large part, Norway's comparatively high overall healthcare spending as well as the positive impact of pharmaceutical regulations promoting the rational use of drugs (Hobaek & Lie, 2019). The proportion of health spending allocated to health system governance and administration was also among the lowest in Europe, at 1.4 % compared to the EU average of 3.7 %. Despite this modest allocation, the Norwegian government is conducting a spending review of central health administration (Saunes, 2023b).

Norway has among the highest numbers of health professionals in Europe

In 2021, Norway had 5.2 practising doctors per 1 000 population – a density nearly 27 % above the EU average and 9 % higher than in 2017 (Figure 10). The density of nurses was more than double the EU average, largely attributable to Norway's substantial allocation of health expenditure to long-term care. Despite the comparatively high number of nurses in Norway, both hospitals and municipalities, which handle the recruitment of nurses in long-term care, have confronted increasing staffing challenges in recent years – not only in rural areas, but also in central regions of the country. Together with recruitment, the retention of nurses has also become a challenge, particularly in long-term care, where their annual turnover surpasses 20 % (Ministry of Health and Care Services, 2023).

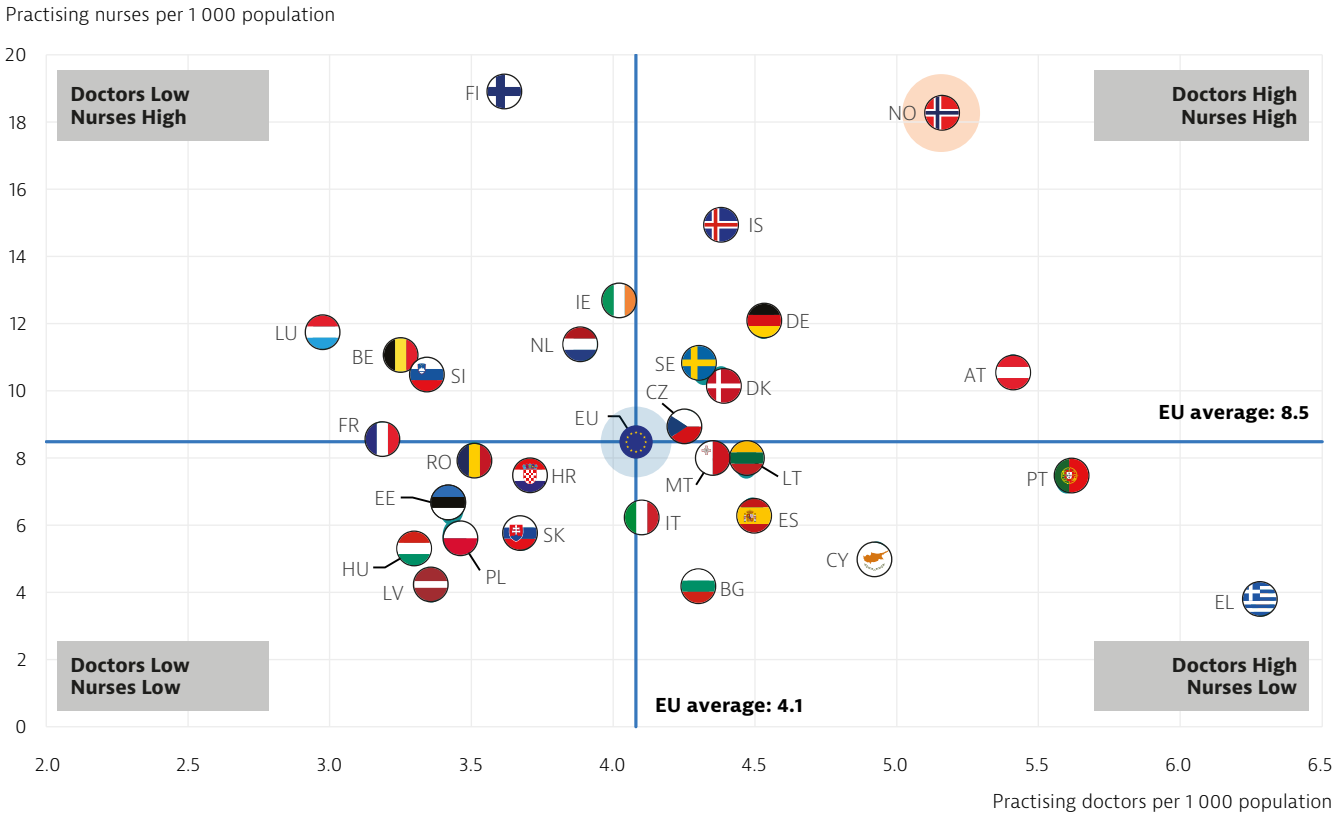
Figure 9. Norway spends the highest amount on long-term care in Europe, both per capita and as a proportion of total health spending



Notes: 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; 6. Includes health system governance and administration and other spending. The EU average is weighted.
Sources: OECD Health Statistics 2023 (data refer to 2021).

Furthermore, there has been a significant increase in the number of nurses opting to work as temporary hires through private staffing agencies within the health service – an arrangement that offers them enhanced flexibility and better average hourly pay compared to salaried nurses (FAFO, 2023). Nonetheless, this trend raises concerns about potential disruptions to care continuity and quality, especially in rural regions, and is detrimental to cost control efforts (Andreassen, 2021). The uneven distribution of the health workforce constitutes a challenge, as some of the more sparsely populated district municipalities experience a low density of healthcare professionals. In the case of GPs, this issue has ultimately culminated in shortages in some regions.

Figure 10. Norway boasts one of the highest concentrations of doctors and nurses in Europe



Notes: The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). 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: OECD Health Statistics 2023 (data refer to 2021 or the nearest available year).

5 Performance of the health system

5.1 Effectiveness

Low rates of preventable deaths reflect comprehensive, universal public health services

Norway consistently maintains one of Europe's lowest mortality rates due to causes that are typically preventable through effective public health and primary prevention interventions. Between 2011 and 2019, Norway's preventable death rate declined by 20 % (from 144 to 115 per 100 000 population), outperforming the EU average decline of 13.5 % despite Norway already recording a below-average preventable mortality rate in 2011. While the EU average rate of preventable deaths increased by 17 % from 2019 to 2020 largely due to the classification of COVID-19 as a preventable cause of death, Norway's rate remained unchanged compared to 2019, reflecting the country's low number of COVID-19 fatalities (see Section 2). Against this backdrop, the recent release of a government White Paper anticipates forthcoming policy measures aimed at strengthening public health (Box 1).

Box 1. Actions to reduce socioeconomic inequalities in health are expected in the near future

In March 2023, the Norwegian government released a White Paper that sets forth options for advancing public health and enhancing citizens' quality of life. The primary objectives of the plan centre on reducing health disparities across socioeconomic groups, and focus on six main areas:

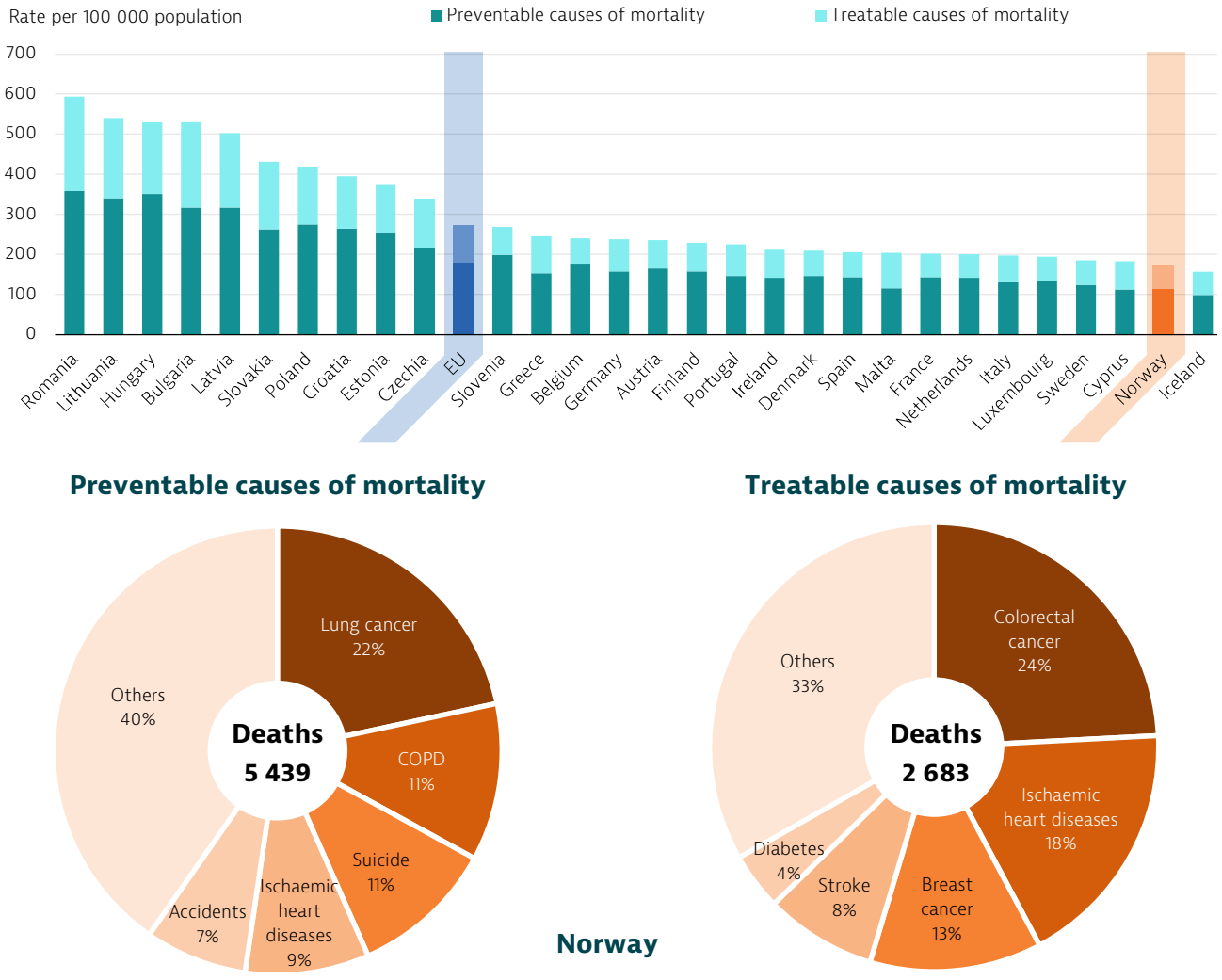
- Socially influenced health determinants
- Lifestyle and the prevention of non-communicable diseases
- Mental health and overall quality of life
- Safeguarding against health threats and the right to a healthy environment
- Effective communication and citizen engagement
- Preventive efforts within the health and care services.

Mortality rates from treatable causes are among the lowest in Europe

In 2020, Norway's mortality from causes deemed generally treatable through effective healthcare interventions stood at only 57 per 100 000 population – a rate 38 % below the EU average and on a par with the Netherlands, which reported the lowest rate in the EU.

Over the past decade, Norway's treatable mortality declined at a considerably swifter pace compared to the EU average, in large part thanks to mortality reductions from ischaemic heart disease and, to a lesser extent, colorectal cancer. Nevertheless, these conditions remained the two leading causes of treatable deaths in Norway, collectively accounting for over 40 % of the total (Figure 11). While Norway's lower rate also partly results from a comparatively low burden of disease, it remains a testament to the robust capability of the

Figure 11. Mortality rates from preventable and treatable causes are among the lowest in Europe



Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death. COPD refers to chronic obstructive pulmonary disease.
Source: Eurostat Database (data refer to 2020).

Norwegian healthcare system to offer swift access to high-quality treatment for life-threatening conditions.

The Norwegian healthcare system has undertaken various measures to enhance the quality of care provided in recent years. A notable example is the establishment of standardised patient care pathways for specific diseases with established treatments. These pathways encompass a range of conditions, including cancer, stroke, musculoskeletal issues, mental health concerns and substance-use disorders. The implementation of standardised patient care pathways for cancer began in 2015, and as of 2023, these pathways have been instituted for 28 distinct cancer types.

Influenza vaccination coverage among Norwegian adults aged 65 and over surpassed the EU average in 2020

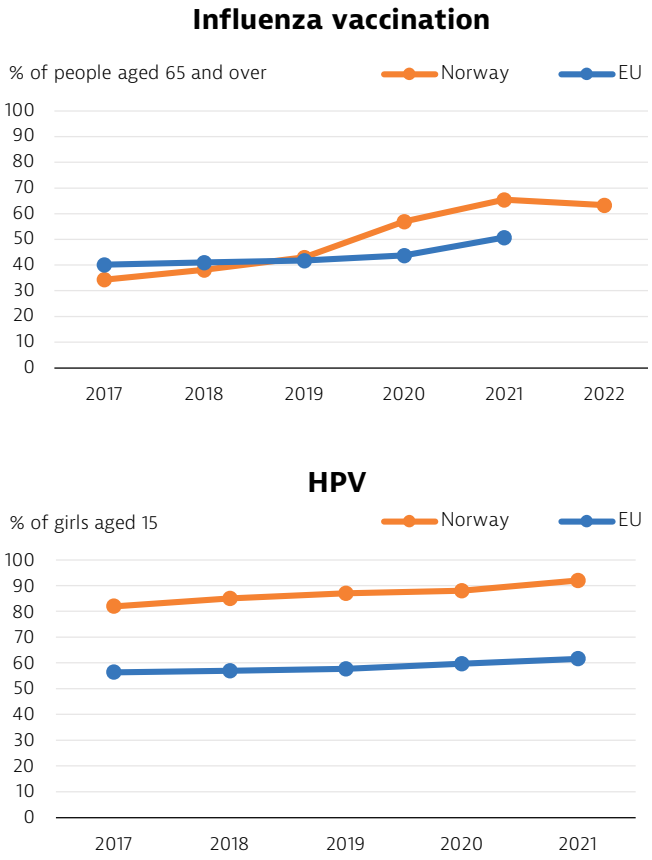
As in most other European countries, Norway has long recommended the influenza vaccine for people aged 65 and over. While the vaccine uptake rate for this age group was lower than the EU average prior to 2019, coverage experienced rapid growth in 2020 (Figure 12). Throughout the pandemic, Norway's influenza vaccine coverage within this target group increased significantly, although it still fell short of the WHO 75 % target rate. The observed elevated flu vaccination uptake in Norway since 2020 can probably be attributed to increased awareness and vaccine interest during the pandemic, along with the authorisation for pharmacists to prescribe the flu vaccine with public reimbursement starting in 2020.

In recent years, Norway has consistently maintained a higher coverage rate for the human papillomavirus (HPV) vaccine compared to the EU average. Through various efforts aimed at increasing its adoption, the uptake of the vaccine among 15-year-old girls surged from approximately 80 % in 2017 to surpassing 90 % in 2022, meeting the WHO target for eradicating cervical cancer. Moreover, beginning in 2018, Norway expanded the eligibility criteria for free HPV vaccination to include adolescent boys.

More effective care coordination could lead to fewer avoidable hospital admissions

Hospital admissions' data for conditions that can generally be managed effectively outside of hospitals provide insights into the availability and effectiveness of outpatient care. While Norway's aggregate admission rate for diabetes, congestive health failure, asthma and chronic obstructive pulmonary disease (COPD) was nearly a quarter lower than the EU average in 2019, in the years

Figure 12. Uptake of flu and human papillomavirus vaccines among their primary target groups has increased significantly in recent years

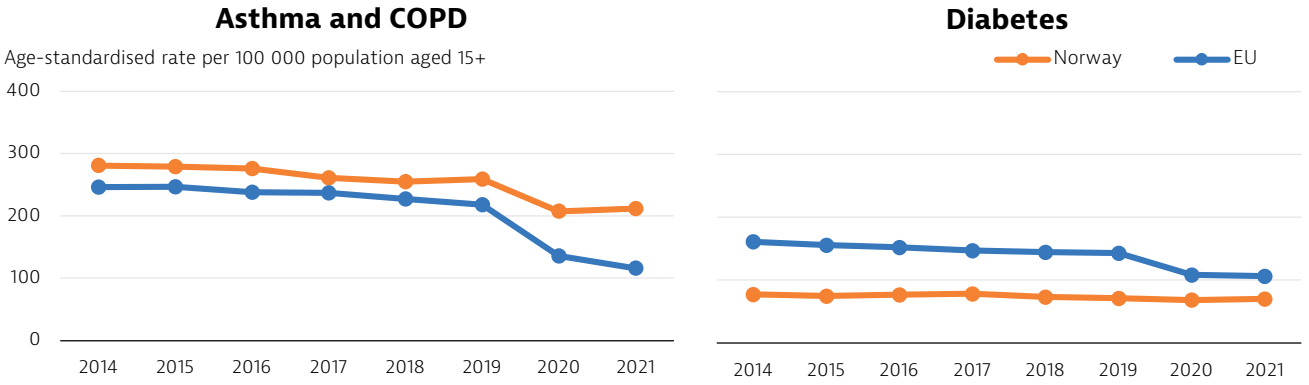


Sources: OECD Health Statistics 2023 and Eurostat Database (influenza) and WHO Immunisation Database (HPV).

leading up to the COVID-19 pandemic Norway registered hospital admission rates for asthma and COPD that were about 10-15 % higher than the EU average. In contrast, diabetes hospitalisations firmly remained at a level about half the EU average (Figure 13).

As the pandemic started in 2020, Norway's admission rate for asthma and COPD declined by 20 % against an EU average decline of 38 %. In contrast to the 25 % decline in admissions for diabetes observed on average across the EU, admission rates in Norway continued declining at a rate in line with the pre-pandemic trend. The marked decline in hospital admissions for asthma and COPD observed in 2020 in both Norway and the EU should be interpreted in the context of the disruption caused by COVID-19, which impacted non-COVID-19 hospital activity and altered healthcare-seeking behaviours (see Section 5.3). These declines cannot therefore be understood as indicative of improved accessibility or quality of care for these chronic conditions in outpatient settings.

Figure 13. Norway has low rates of avoidable admissions from diabetes, but rates for respiratory conditions are above the EU average



Note: Admission rates are not adjusted for differences in disease prevalence across countries.
Source: OECD Health Statistics 2023

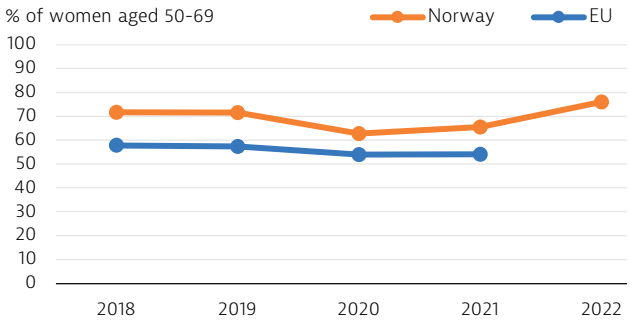
To improve care coordination, follow-up and monitoring of patients with chronic conditions, a new model of multidisciplinary primary care teams including nurses and health secretaries has been piloted in the years 2018-23. In recent years, hospitals have also been given greater responsibility in coordinating discharges – for example, through the creation of discharge checklists and requirements to coordinate post-discharge patient follow-up with municipalities.

Cancer screening efforts were intensified in 2021 and 2022 to clear the backlog from 2020

As in most other European countries, the pandemic had an adverse effect on Norway's cancer screening programmes in 2020. Screening for breast cancer was temporarily halted in mid-March 2020. Some mammography centres gradually resumed operations in May and June, while others reopened in August. Invitation sending was paused for two months, and staff were temporarily redirected to symptomatic services, prioritising high-risk patients in the diagnostic pathway. As a result of the temporary shutdown, Norway's breast cancer screening rate declined by nearly 9 percentage points to 63 % in 2020. The combination of reduced screening, difficulties in accessing GPs as well as patients' hesitancy to seek medical care for fear of contracting the virus resulted in a decrease in the number of breast cancer cases diagnosed in Norway in 2020. Against the backdrop of a 1.1 % average annual increase in the incidence of breast cancer in the five years before the pandemic, the age-adjusted incidence rate fell by over 9 % in 2020.

As screening activity ramped up significantly in the subsequent years, the breast cancer screening rate rebounded to 65.5 % in 2021 and reached an all-time-high of 76 % in 2022 (Figure 14). In 2021, Norway's breast cancer incidence rate surged by 15.4 % in 2021 – reaching a level 5 % higher than that of 2019. In 2022, the incidence rate registered a more modest uptick of 2.9 % close to the pre-pandemic trend, suggesting a substantial resolution of the diagnostic backlog that had accumulated during the pandemic.

Figure 14. Norway's breast cancer screening rate surpassed its pre-pandemic level in 2022



Note: The rate refers to the share of individuals within the target group who undertook screening in the last two years.
Source: OECD Health Statistics 2023 (based on national programme data).

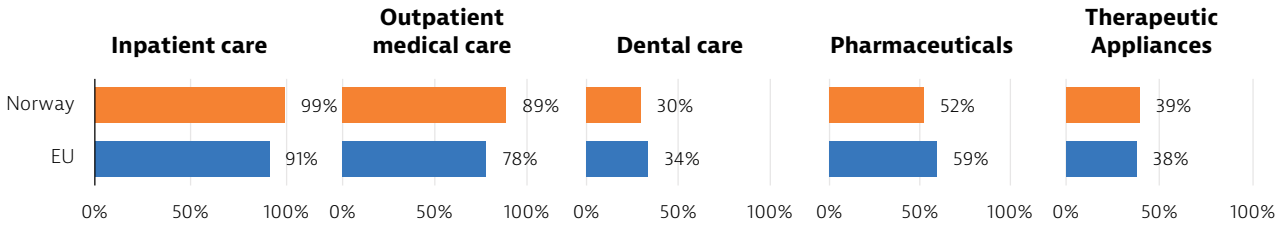
While official data on Norway's cervical cancer screening rates throughout the pandemic are currently unavailable, in 2019 78 % of Norwegian women aged 25-69 years old underwent a cervical smear test within the previous three years – a proportion significantly above the EU average. Similarly to breast cancer, cervical cancer screening activities were temporarily suspended in March and April of 2020. While the age-adjusted incidence rate of cervical cancer fell by 7.5 % in 2020, it remained stable in 2021 and fell by 20 % in 2022. In late 2022, Norway started running a population-based screening programme for colorectal cancer, the second most frequent cancer diagnosed in the country (see Section 2). The programme entails faecal immunochemical test (FIT), and targets all people aged 55 and older.

5.2 Accessibility

Norway's healthcare system guarantees near-complete coverage for inpatient and outpatient care

An examination of public financing ratios for specific health system functions provides additional insight into the scope of financial protection provided by the Norwegian healthcare system to its citizens. In 2021, it guaranteed near-complete coverage for the costs of inpatient care (Figure 15). Similarly, public coverage for outpatient care was nearly 90 %, exceeding the EU average. In contrast, public coverage rates for dental care and pharmaceuticals were below the relevant EU averages.

Figure 15. Norway's public benefits package covers virtually all costs of inpatient care



Notes: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines and medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices.
Source: OECD Health Statistics 2023.

Robust public coverage results in low unmet needs for medical care irrespective of income

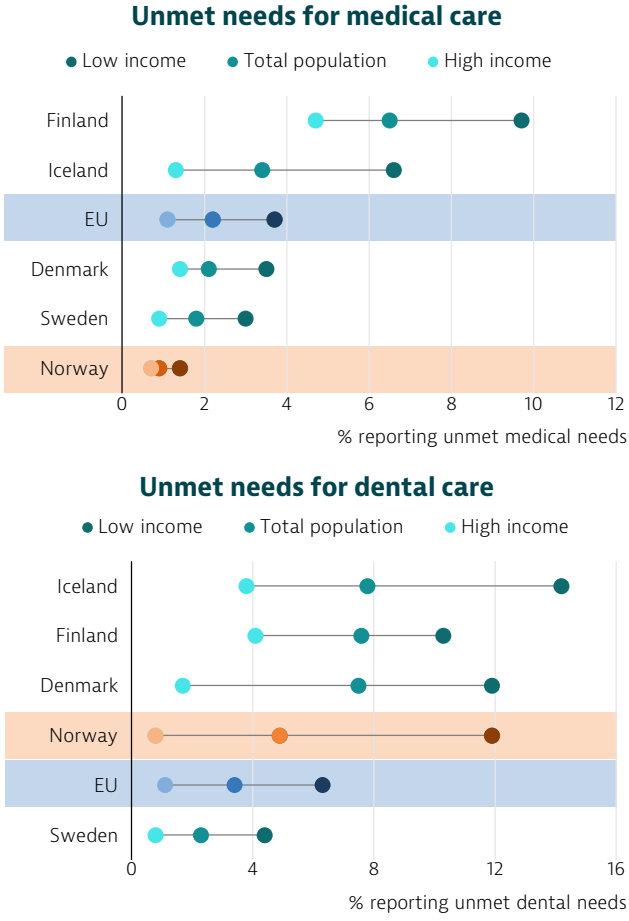
In 2020 (latest year available), fewer than 1 % of Norwegians reported unmet needs for medical care due to cost, distance to travel or waiting times, with waiting times the main driver of reported unmet needs. The proportion of Norwegians reporting unmet needs was approximately half the EU average and stood as the lowest among Nordic countries. While a slightly greater proportion of individuals in the lowest income quintile reported unmet medical care needs than those in the highest quintile, the gap was the narrowest among Nordic countries (Figure 16).

Unmet needs for dental care were more prevalent, affecting approximately 5 % of the population in 2020. Cost was the main reason for these unmet needs, reflecting the comparatively low extent of public coverage for dental care. In 2020, 12 % of residents in the lowest income quintile reported unmet dental needs, in stark contrast to merely 1 % of those in the highest quintile – the widest gap across income groups among Nordic countries. In August 2022, the government established a public committee tasked with assessing potential models for dental care that would ensure enhanced accessibility. The final report from the committee is expected to be finalised by June 2024.

Out-of-pocket health spending is mainly directed to pharmaceuticals and dental care

As discussed in Section 4, the financing structure of the Norwegian healthcare system is characterised by a notably higher share of spending

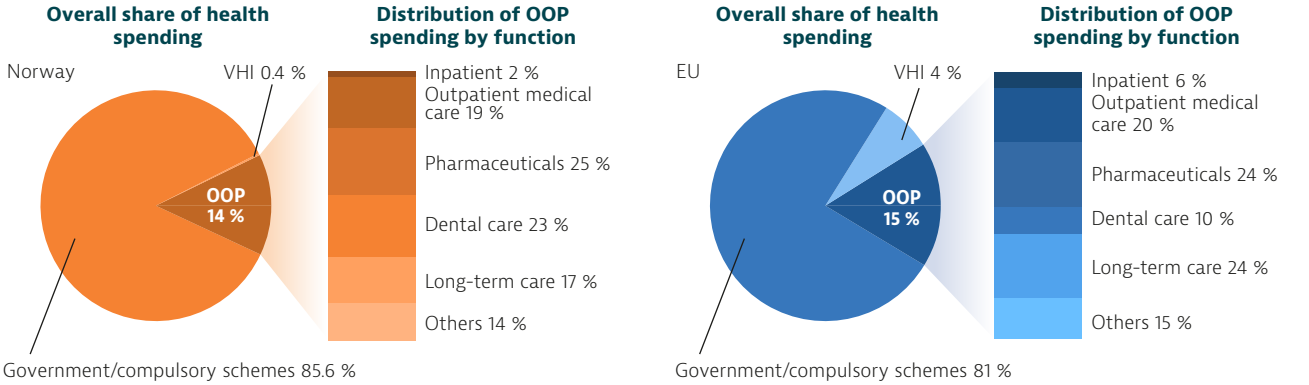
Figure 16. Unmet medical care needs are minimal, yet unmet dental care needs reveal significant income-based disparities



Notes: Data refer to unmet needs for a medical or dental examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.
Source: Eurostat Database, based on EU-SILC (data refer to 2022, except Norway (2020) and Iceland (2018)).

originating from public sources compared to the EU average. At the same time, the proportion of out-of-pocket (OOP) expenditure is only marginally lower than the EU average, owing to the near-absence of private voluntary health insurance (VHI) in the country (Figure 17). In 2021, OOP spending by Norwegian households, which mostly comprises copayments, accounted for 98 % of private health expenditure. Its allocation across services was comparable to the EU average, with over 40 % of OOP spending directed towards retail pharmaceuticals and outpatient medical care. In contrast to the EU average, dental care absorbed nearly a quarter of total OOP expenditure, reflecting Norway's comparatively narrower public coverage in this area.

Figure 17. Dental care and retail pharmaceuticals make up nearly half of out-of-pocket spending



Note: VHI also includes other voluntary prepayment schemes.
Sources: OECD Health Statistics 2023; Eurostat Database (data refer to 2021).

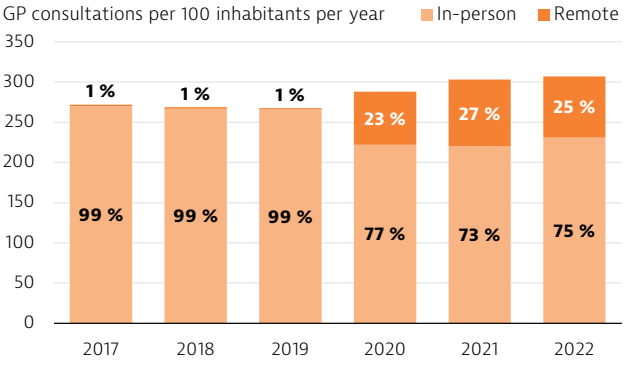
Regional health authorities did not achieve waiting time reduction targets in 2022

Norway's Patients' Rights Act stipulates that patients are entitled 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. The Minister of Health and Care Services set a goal for all regions to reduce average waiting times in 2022 compared to 2021, and to ensure that the average waiting time for hospital care remains below 50 days. However, none of the four RHAs reached the goal of reducing waiting times in 2022 compared to 2021. The overall average waiting time for specialist healthcare increased from 61 days in 2021 to 66 days in 2022 (Directorate of Health, 2023a). Average waiting times increased from 63 to 68 days for somatic services, from 64 to 50 days for mental healthcare for adults, and from 50 to 53 days for mental healthcare for children.

Teleconsultations peaked in 2021, accounting for over a quarter of total primary care consultations

Telemedicine played a large role in maintaining access to ambulatory care during the pandemic. At the start of the pandemic in March 2020, healthcare providers were instructed to switch to teleconsultations (video, phone or chats). This resulted in a massive increase in the number of remote GP consultations, which practically did not exist prior to the pandemic (Figure 18). The volume of teleconsultations peaked in 2021, accounting for over 27 % of total primary care consultations. Against the backdrop of a slight increase in the number of in-person GP consultations between 2021 and 2022, the number of teleconsultations remained significant, but decreased slightly from 83 to 76 per 100 inhabitants.

Figure 18. Teleconsultations more than compensated for the decline in in-person GP visits since the start of the pandemic



Source: Directorate of Health (2023b).

5.3 Resilience

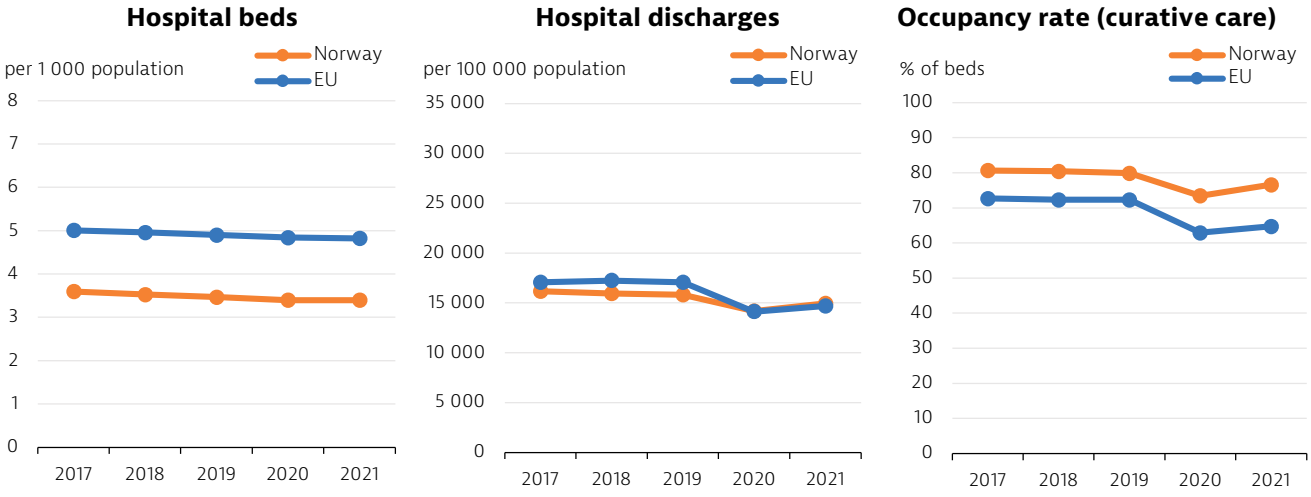
The COVID-19 pandemic has proved to be the most significant disruption to health systems in recent decades. It has shed light on the vulnerabilities and challenges within countries' emergency preparedness strategies and on their ability to provide healthcare services to their populations. In response to the enduring effects of the pandemic – as well as other recent crises, such as cost-of-living pressures and the impact of conflicts like the war against Ukraine – countries are implementing policies to mitigate the ongoing impacts on service delivery, invest in health system recovery and resilience,[2] improve critical areas of the health sector, and fortify their preparedness for future shocks.

Following a 10 % decline in 2020, hospital admissions returned to near pre-pandemic levels in 2021

Although to a lesser degree than in other Nordic countries, Norway's hospital capacity is lower than the EU average, owing in part to effective outpatient care and strict gatekeeping at the primary care level. In line with the general trend in the EU, Norway experienced a consistent decline in hospital bed density over the 10 years preceding the pandemic, from 4.3 beds per 1 000 inhabitants in 2010 to 3.5 per 1 000 in 2019 – significantly below the EU average of 4.9 per 1 000. This trend came to a halt in 2021, when bed capacity in Norwegian hospitals held steady at 3.4 beds per 1 000 inhabitants – the same as in 2020. In the five years leading up to the pandemic, Norwegian hospitals operated at high efficiency, recording discharge rates approximately 6 % below the EU average despite a nearly 30 % lower bed density, and an acute care bed occupancy rate of around 80 %.

At the start of the COVID-19 pandemic, Norway implemented various measures minimise the risk of hospital outbreaks and establish a resource buffer of beds, personnel and equipment – including through the deferral of substantial volumes of non-urgent hospital services. These contingency measures resulted in sizeable declines between 2019 and 2020 in both inpatient discharges (-10 %) and average bed occupancy rates (-8 %) (Figure 19). In 2021, both measures partially recovered to approximately 95 % of their 2019 levels.

Figure 19. Hospital discharges and acute care bed occupancy rates rebounded partially in 2021



Sources: OECD Health Statistics 2022 and Eurostat Database.

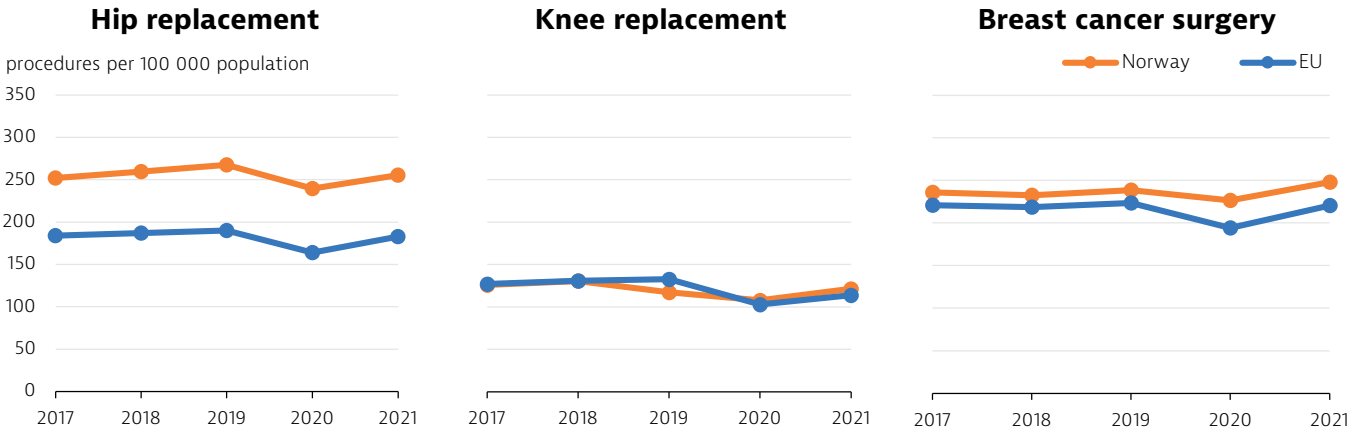
Volumes of elective surgical procedures experienced a robust rebound in 2021

Before the pandemic, Norway's rates of surgical procedures for breast cancer and knee replacements were comparable to their respective EU averages, whereas the hip replacement surgery rate exceeded the EU average by over a third. As a result of the contingency measures implemented in hospitals at the onset of the pandemic, Norway witnessed a nearly 10 % reduction in hip and knee replacement surgeries in 2020. In contrast, the breast cancer surgery rate experienced a more modest decline of 5 %, which was notably smaller than the 13 % decline observed across the EU (Figure 20).

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).*

With the gradual resumption of non-COVID-19-related activities in 2021, volumes of elective surgery in Norwegian hospitals experienced a significant rebound. While hip replacement surgery fell short of returning to its pre-pandemic rate, both knee replacement and breast cancer surgery surpassed their respective 2019 rates by approximately 3 %. This achievement underscores the resilience of Norwegian hospitals and their capacity to promptly address backlog of elective surgeries that had accumulated throughout 2020.

Figure 20. The volume of elective surgical procedures rebounded significantly in 2021



Source: OECD Health Statistics 2023.

The pandemic did not disrupt long-term government health spending trends in Norway

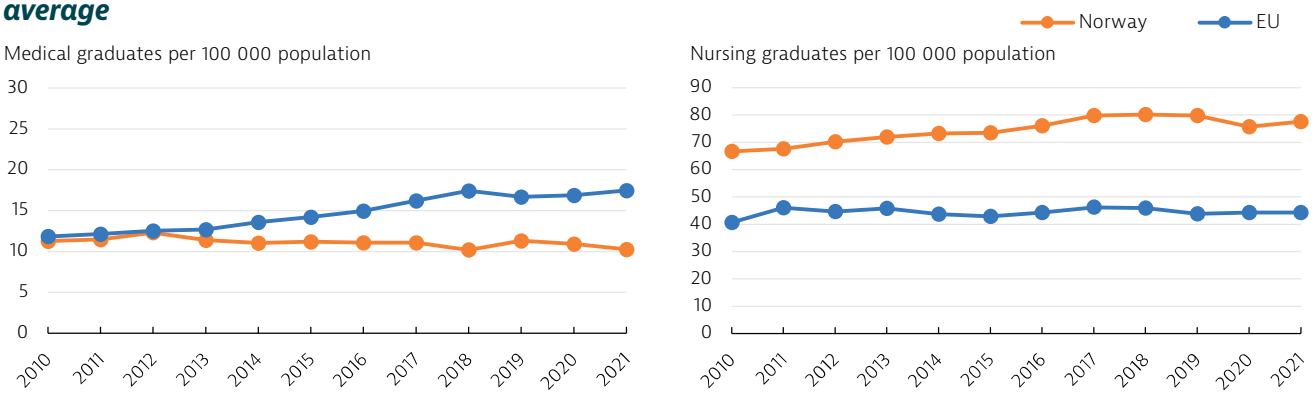
Between 2014 and 2019, Norway's government health expenditure experienced an average annual growth of 2.4 % in real terms, surpassing the country's average yearly GDP growth of 1.5 % over the same period. Unlike in most other European countries, the pandemic did not significantly disrupt this trend, as throughout the first two years of the pandemic, government health spending growth consistently outpaced GDP fluctuations. Against the backdrop of a 1.3 % decline in GDP in 2020, Norway's public spending on health grew by 0.8 % – one of the lowest growth rates observed across European countries, reflecting Norway's significantly reduced outpatient and hospital activity and a relatively low number of COVID-19 hospitalisations in 2020. As GDP increased by 3.9 % in 2021, public health expenditure rose by 4.4 %, driven in large part by COVID-19-related costs – including vaccines and tests, which jointly accounted for 3.2 % of Norway's government expenditure on health in 2021.

The government is assessing measures to support long-term health workforce planning

Compared to the EU average, Norway trains fewer medical graduates and a higher number of nursing graduates annually. As a result, Norway has a higher share of non-domestically trained active physicians than many EU countries. While on average across the EU the annual number of medical graduates per 100 000 population increased by approximately 40 % between 2010 and 2020, in Norway's rate remained stable (Figure 21). As a result, over the last five years Norway's average annual number of medical graduates per 100 000 population was approximately two thirds of the EU average. Conversely, Norway's annual nursing graduate output grew by over 10 % between 2010 and 2020, whereas the EU average remained relatively unchanged. On average over the past five years, the number of nursing graduates trained annually in Norway was nearly three quarters higher than the EU average.

The importance of scaling up health workforce training capacity to safeguard the long-term sustainability of the Norwegian healthcare system has been emphasised in a recent report by the Healthcare Personnel Commission (Helsepersonellkommisjonen), an expert group that received a government mandate in 2021 to conduct a detailed scenario assessment of the needs for professional needs and competences in Norway's healthcare sector until 2040. In their report, the Commission presented a series of recommendations concerning education, recruitment and retention of qualified health and long-term care professionals. These measures are in large part aimed at addressing the dual challenge of increasing healthcare demand and the constrained labour supply resulting from the anticipated demographic shift in the country (NOU, 2023).

Figure 21. Norway trains fewer medical graduates and more nursing graduates compared to the EU average

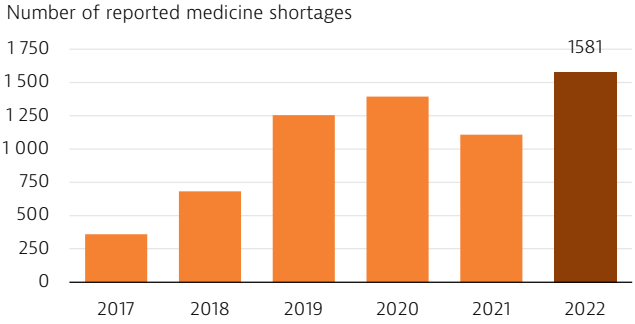


Sources: OECD Health Statistics 2023; Eurostat Database.

Norway introduced some measures to mitigate medicine shortages during the pandemic

Since the start of the COVID-19 pandemic, the number of medicine shortage notifications issued by Norwegian Medicines Agency increased markedly (Figure 22). Notifications reached an all-time high in 2022, reflecting the ripple effects of heightened demand and disrupted supply chains that reverberated throughout Europe. In response to this problem, the Norwegian Medicines Agency introduced a series of mitigating measures. For example, in 2020 the Agency instated a temporary 15 % price hike for selected generic medicines as an incentive for manufacturers to ramp up their production capacity. Additionally, the agency granted authorisation for the sale of generic medicines with labelling and patient information leaflets not intended for the Norwegian market.

Figure 22. The number of medicine shortage notifications in Norway peaked in 2022



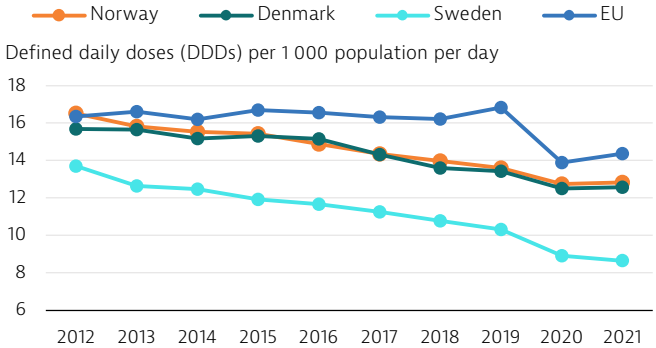
Source: Norwegian Medicines Agency.

Norway's antibiotic consumption remains consistently below the EU average

Antimicrobial resistance (AMR) is a major public health concern in Europe, with estimates of about 35 000 fatalities and healthcare-associated costs of around EUR 1.1 billion per year in the EU and the European Economic Area (EEA) due to antibiotic-resistant infections (OECD/ECDC, 2019). Because antibiotic overprescription and overuse in humans are major contributors to the development of antibiotic-resistant bacteria, antibiotic consumption data are a useful tool to evaluate the risk of AMR and the efficacy of programmes to promote their appropriate use.

Norway's performance in this regard is better than the EU average. Between 2016 and 2021, total antibiotic consumption in the country decreased at an average rate of 2.9 % per year, resulting in a total consumption rate over 14 % below the EU average in 2021. This decline was largely propelled by decreased prescriptions in community settings, which account for over 90 % of Norway's total antibiotic consumption. In contrast to the situation observed in the EU on average, the COVID-19 pandemic did not prompt a steep decline in antibiotic consumption in Norway. Between 2019 and 2021, community antibiotic consumption continued to decline at a rate in line with its long-term trend (Figure 23). However, part of the observed decline may be linked to a reduction in the number of infections caused by pandemic containment measures that Norway implemented during the pandemic.

Figure 23. Outpatient antibiotic consumption continued to decline at a rate in line with the pre-pandemic trend during the pandemic



Note: The EU average is unweighted. The data only cover consumption in the community (outpatient).
Source: ECDC ESAC-Net.

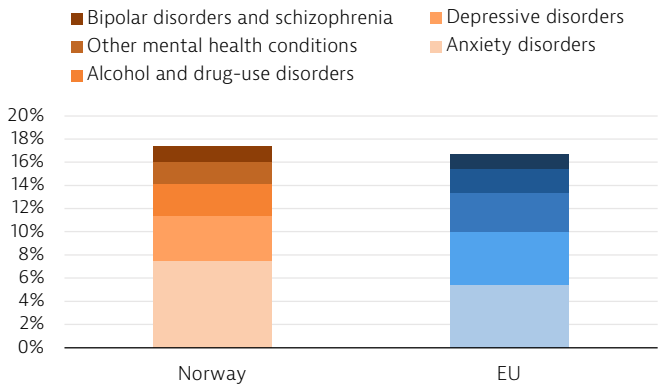
6 Spotlight on mental health

The burden of mental health in Norway is somewhat higher than the EU average

As in other countries, determining the exact proportion of the Norwegian population affected by a mental health disorder at any point in time is challenging due to methodological limitations specific to mental disorders, which often result in undercounting their true burden.

According to prevalence estimates from the Institute for Health Metrics and Evaluation (IHME), over 943 000 individuals in Norway had a mental health disorder in 2019, representing 17.6 % of the population – slightly above the EU average of 16.7 %. Among these disorders, anxiety disorders were the most prevalent, impacting around 8 % of Norwegians. Depressive disorders followed at 4 %, while alcohol and drug use disorders affected 3 % of the population (Figure 24).

Figure 24. More than one in six people in Norway had a mental health disorder in 2019



Source: Eurostat Database.

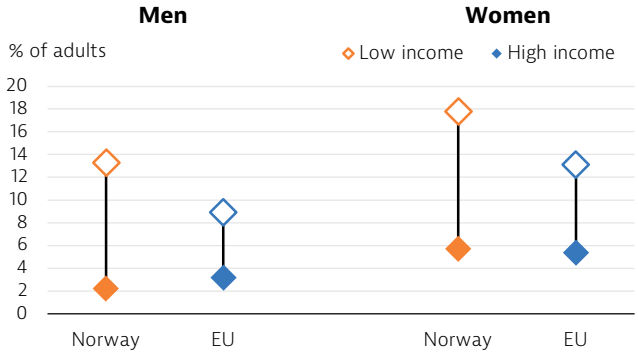
Mental health disorders are a key cost driver of the healthcare system in Norway

Estimates from Norway's Directorate of Health (2019) highlight the substantial contribution of mental health issues to societal costs attributed to diseases in Norway. In 2015, mental disorders were linked to 12 % of total healthcare expenditure and estimated to account for approximately EUR 5 billion in productivity losses, constituting over a quarter of total disease-related productivity losses. In a more recent study estimating Norwegian 2019 healthcare spending by health condition, mental health and substance-use disorders collectively accounted for over one fifth of total healthcare spending (Kinge et al., 2023).

Depression tends to be more prevalent among those on lower incomes and women

Based on survey data, over 8 % of Norwegians reported experiencing depression in 2019 – a slightly higher proportion compared to the EU average of 7.2 %. As in all other European countries, depression was more common among women (10.2 %) than men (6.6 %). The gender gap in the prevalence of depression among Norwegians was comparable to the EU average. As in most other European countries, higher income levels consistently correlated with lower depression rates. 15.8 % of Norwegians in the lowest income quintile reported experiencing depression in 2019 compared to only 3.7 % of Norwegians in highest quintile – a more pronounced difference compared to the EU average (Figure 25).

Figure 25. Women and people in the lowest income quintile are more likely to report depression



Note: High income refers to people in the top income quintile (20 % of the population with the highest income), whereas low income refers to people in the bottom income quintile (20 % of the population with the lowest income).
Source: Eurostat Database (EHIS 2019).

Limited availability of mental health professionals creates barriers to accessing specialised care in sparsely populated regions

Public mental healthcare services in Norway are delivered through primary care settings and hospitals, with municipalities being responsible for organising the provision of services. GPs serve as initial point of contact for the vast majority of patients seeking mental healthcare. They are responsible for treating mild to moderate mental health conditions, as well as providing follow-up care for more severe cases. In 2020, about 15 % of men and 22 % of women in Norway consulted their GP for mental health support. Patients with more

severe conditions receive treatment in hospitals and specialised outpatient clinics. In 2020, 5 % of men and 7 % of women in Norway used specialist mental healthcare services (Norwegian Public Health Institute, 2023).

As with other hospital services in Norway, a GP referral is needed for an appointment with a specialist. However, long waiting lists and geographical disparities in the supply of mental health professionals hinder access to mental health services in several parts of the country. While every municipality in Norway is legally mandated to offer access to a psychologist, one in five did not meet this requirement in 2023. While municipalities in central areas often employ their own psychologists, this practice is notably less prevalent in rural areas.

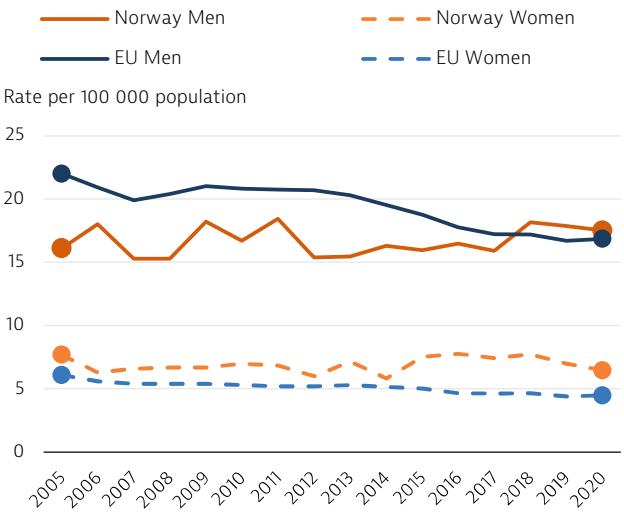
Suicide rates have remained stable over the past decade, including during the pandemic

Suicide is significant public health problem in Europe, including in Norway, where it accounted for 648 deaths (1.6 % of all fatalities) in 2020. While the factors contributing to suicide are complex, extensive research and clinical practice have established that mental health problems play a substantial role as risk factors for suicide. In 2020, the suicide rate in Norway stood at 12 per 100 000 population – slightly above the EU average of 10.24 and aligning with rates reported by other Nordic countries. As in the rest of Europe, suicide rates in Norway are characterised by a marked gender split, with a higher incidence amongmen (Figure 26). Despite concerns around risks of an increase in suicides during the pandemic, data from 2020 and 2021 from the Norwegian cause of death registry show that there was no significant rise in the occurrence of suicide in the first two years of the pandemic, and that incidence did not significantly increase during lockdowns (Stene-Larsen et al., 2022).

Norway's consumption of antidepressants is the lowest among Nordic countries

Over the last decade, the use of psychoactive medications has generally risen across European countries, including Norway. However, compared to other Nordic countries, Norway's increase in antidepressant consumption has been notably modest, growing by less than 6 % from 2011 to 2021, in contrast to the average increase of over 26 % seen among Nordic countries. In 2021, Norway's antidepressant consumption reached 61 defined daily doses per 1 000 inhabitants/day, which was nearly 40 % below the Nordic average. In the same year, approximately 372 000 individuals

Figure 26. Suicide rates among Norwegian men remained stable over the past decade.



Source: Eurostat Database.

in Norway received at least one antidepressant prescription, equivalent to 6.9 % of the population – a lower proportion compared to the Nordic average of 10.7 % (Nomesco, 2023).

In contrast to the prescription trend for antidepressants, anxiolytic prescription rates in both Norway and other Nordic countries notably declined over the past decade. Between 2011 and 2021, Norway's anxiolytic consumption rate decreased by over a third, in line with the trend observed across other Nordic countries.

Norway implemented various policies aimed at strengthening mental health in the wake of the pandemic

In 2021, the Norwegian government established an expert committee to assess the repercussions of the COVID-19 pandemic on the population's quality of life, mental health and rates of substance use. The committee concluded that the current services were functioning reasonably well, thereby necessitating no major restructuring. It recommended measures to enhance coordination between the public and voluntary sectors, fostering citizens' engagement in their own mental healthcare and active participation in mental health promotion initiatives. As a follow-up, in 2022 the Norwegian government introduced a new public health campaign titled ABC (Act, Belong, Commit) for Mental Health. This campaign was inspired by a successful initiative launched by the Danish government in Denmark. Its purpose is to enhance public understanding of mental health and raise awareness among the population about the importance of physical activity and nurturing relationships for mental well-being.

7 Key findings

- In 2022, Norway's life expectancy at birth stood at 82.6 years – nearly 2 years above the EU average. While it remained above its pre-pandemic level during the first two years of the pandemic, life expectancy fell by half a year in 2022, largely due to a significant increase in COVID-19 deaths. In 2020, the leading causes of mortality were cancer and circulatory diseases, which accounted for more than half of all fatalities.
- About a third of all deaths in Norway in 2019 were linked to behavioural risk factors – a proportion below the EU average. While adult obesity rates are low compared to the EU average, adolescent overweight and obesity rates have been rising toward levels close to the EU average. Smoking prevalence is also among Europe's lowest, and snus is the predominant tobacco consumption mode, which is especially popular among young adults. Due to strict sales and advertising policies and high excise duties, per capita alcohol consumption is nearly one quarter below the EU average.
- Norway's health expenditure ranks among the highest in Europe on a per capita basis, although it is below the EU average when measured as a share of GDP. Government funding accounts for 86 % of health spending – a high share compared to other European countries. Norway allocates a large proportion of its health budget to long-term care, while expenditure on outpatient pharmaceuticals is comparatively low both in per capita terms and as a proportion of total spending. Health expenditure per capita grew by 4.3 % in real terms between 2019 and 2021 – a relatively modest increase, which was primarily driven by government spending in 2021.
- Norway's healthcare system offers universal access to a comprehensive benefits package. While public coverage is among the highest in Europe, the proportion of expenditure financed out of pocket is in line with the EU average, owing to the near-absence of private health insurance. Unmet medical care needs are low across all income groups, and are predominantly related to waiting times. However, unmet dental care needs are high and exhibit relatively wider income-based disparities.
- Owing to a comparatively low disease burden and high quality of acute care, Norway has one of the lowest death rates from potentially treatable causes in Europe. Cancer screening programmes faced challenges in 2020, with breast cancer diagnoses falling by 9 % from the previous year. However, diagnostic backlogs were swiftly resolved, and the breast cancer screening rate exceeded its pre-pandemic level in 2022. Furthermore, in late 2022, Norway initiated a population-based screening program for colorectal cancer.
- While Norway boasts among the highest numbers of doctors and nurses per capita in Europe, in recent years both hospitals and municipalities have begun experiencing staffing difficulties, with low numbers of nurses and GPs in various regions. Norway trains fewer medical graduates annually than the EU average, but produces a much higher number of nursing graduates. Recognising the importance of maintaining an adequate supply of skilled health professionals amid an ageing population, Norway is developing a long-term health workforce development strategy.
- The prevalence of mental health disorders in Norway is slightly above the EU average, with an estimated 17.6 % of the population affected in 2019. These disorders imposed a significant financial burden on the healthcare system, accounting for as much as 20 % of total healthcare expenditure that year. Depression rates are higher among Norwegian women, and depression is more prevalent among individuals on lower incomes. Suicide remains a public health concern, constituting over 1.6 % of deaths in 2021. Despite the absence of a discernible impact of the pandemic on the mental health of Norwegians or demand for mental health services, Norway implemented various measures aimed at reinforcing mental health promotion and prevention efforts in the last two years.

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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 2023

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2023 edition of the Country Health Profiles provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- For the first time in the series, an account of the state of mental health and related services within the country.

Complementing the key findings of the Country Health Profiles is the Synthesis Report by the European Commission.

For more information, please refer to: ec.europa.eu/health/state

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