HEALTHCARE FINANCING AND REIMBURSEMENT: A GLOBAL REVIEW OF MAJOR TOPICS AND TRENDS

Authors:
Marie Vaale-Hallberg, Ingvild Hanssen-Bauer and Jacob Friis Gottrup, Kvale
mvh@kvale.no, ihb@kvale.no and jgo@kvale.no

LAWS AND REGULATIONS ON HEALTHCARE FINANCING AND REIMBURSEMENT

1. Please provide a bird's-eye view on the healthcare economy, indicating, in general terms, the role of the government (public healthcare) and private actors (private healthcare).

The Norwegian healthcare system is predominantly publicly funded through general taxation and operates under the principle of universal health coverage, with the National Insurance Scheme (*Folketrygden*) playing a central role. All residents are covered by the National Insurance Scheme, managed by the Norwegian Health Economics Administration (*Helseøkonomiforvaltningen* – Helfo). This means that the entire population is (fully or partially) insured against expenses for necessary healthcare services, and that the public healthcare system is obligated to offer necessary medical assistance to all individuals in need.

The national government is responsible for funding, regulating, and overseeing the healthcare system. This guarantees equitable access to healthcare services for all individuals, regardless of their socioeconomic status or geographical location. In practice, the Ministry of Health and Care Services ('the Ministry') is in charge of the regulation and supervision of the system, although many of these responsibilities are delegated to various agencies, such as the Norwegian Directorate of Health (*Helsedirektoratet*).

The Ministry manages hospital and specialty care through four regional health authorities (RHAs), which are controlled by the Ministry through budgets and letters of instructions. Local municipalities are responsible for primary care, preventive services, and long-term care.

The government aims to keep individual healthcare costs manageable by covering the vast majority of expenses through public funds in terms of specialty care, primary care, preventive services, and long-term care. Patients may have to make copayments for certain services, but there are caps on out-of-pocket contributions. Compared to most other countries, any such user copayment is relatively low.

While the public sector dominates, private healthcare also plays a role in Norway, albeit a smaller one, due to the extensive access to public healthcare. Private healthcare providers offer supplementary services, often to reduce waiting times or provide additional choices to patients. This includes private hospitals, clinics, and specialists.

Overall, the Norwegian healthcare system is designed to guarantee high-quality healthcare for all residents, with the government playing a central role in funding and regulation, while private sector provides additional support and options to enhance the system's efficiency and responsiveness.

2. Please provide a high-level overview of the legal framework regarding healthcare financing and reimbursement.

Chapter 5 of the National Insurance Act (*Folketrygdloven*)(and regulations issued pursuant to this act) is of particular importance in terms of healthcare financing and reimbursement in Norway.

The National Insurance Act is the cornerstone of Norway's healthcare system, establishing the National Insurance Scheme which provides universal health coverage for all Norwegian residents. It specifies the rights and obligations related to healthcare services, including funding and reimbursement mechanisms. Accordingly, the act specifies that all members of the National Insurance Scheme (See also Q5) are granted, *inter alia*, (1) reimbursement for necessary medical examinations and treatments by doctors, including general practitioners (GPs) and specialists, (2) coverage for essential medications, including those used in hospitals, (3) support for medical expenses related to pregnancy, childbirth, and family planning, (4) financial assistance for rehabilitation services and (5) financial support for specific dental treatments.

Further detailed rules regarding the specific funding and reimbursement mechanisms are outlined in regulations, such as the Regulation on Grants for Covering Expenses for Examination and Treatment by a Doctor and Regulation on Deductible Cap.

Although industry codes and private norms play a role in the Norwegian healthcare system, their role is limited when it comes to the subject matter of financing and reimbursement. Instead, such codes and norms mainly relate to ethical standards and general industry standards, eg, the Norwegian Medical Association's code of conduct, and the code of conduct of The Norwegian Association of Pharmaceutical Manufacturers and the association for medical devices manufacturers, Melanor.

Negotiations are primarily relevant in terms of the municipalities contracting with individual GPs. GPs' income is based on a combination of payments from (1) the municipalities, (2) the government on a fee-for-service basis through the Norwegian Health Economics Administration, and (3) out-of-pocket payments by patients. GP financing is determined at the national level through negotiations involving the Norwegian Medical Association, the central government (represented by the Ministry, Ministry of Finance, and Directorate of Health), as well as representatives from the RHAs and the Association of Municipalities.

3. What are the key regulators and supervisory bodies regarding healthcare financing and reimbursement?

There are two central government agencies, namely the Ministry and the Norwegian Health Economics Administration.

The Ministry is the primary authority responsible for health policy, legislation, and the overall management and funding of the healthcare system. The Ministry oversees the implementation of national health policies and guarantees that healthcare services are provided in accordance with legal standards.

The Norwegian Health Economics Administration administers the National Insurance Scheme and handles reimbursements for healthcare services, including pharmaceuticals and dental care. It ensures that healthcare providers and patients receive appropriate payments and reimbursements pursuant to the law.

In addition, there are a number of specialised bodies and authorities. While these play an important role in terms of the provision and management of health care services, their role in terms of healthcare financing is smaller.

- Norwegian Directorate of Health (*Helsedirektoratet*): This directorate provides professional advice to the Ministry of Health and Care Services, implements national health policies, and ensures the quality and efficiency of healthcare services. It also plays a role in public health initiatives and preventive care.
- Norwegian Medical Products Agency (*Direktoratet for medisinske produkter* – DMP): This agency is responsible for the regulation and supervision of pharmaceuticals and medical devices. It ensures that medicines and medical products are safe, effective, and of high quality. It also handles the pricing and reimbursement of pharmaceuticals.

In Norway, the role of the courts is to interpret healthcare laws and resolve disputes related to healthcare financing and reimbursement. They ensure that the rights of patients and healthcare providers are protected under the law. Accordingly, they may handle cases involving reimbursement disputes, maximum prices of pharmaceuticals, regulatory compliance, and other legal issues arising within the healthcare system. See also Q14.

4. Has there been a change with healthcare financing and reimbursement as a consequence of the Covid-19 pandemic?

The pandemic has not changed the general system and mechanisms of healthcare financing as such. However, the government in Norway has recognised that the pandemic – and the extraordinary costs that followed from handling the pandemic – have posed a challenge to the operation of, in particular, hospitals in Norway. Accordingly, after the pandemic, the Norwegian government has increased its spending in the healthcare sector. This includes investments aimed at reducing waiting times, strengthening mental health services, and improving the overall healthcare infrastructure.

Further, there have been notable shifts in healthcare budgets to prioritise areas that were significantly impacted by the pandemic. This includes increased funding for mental health services, primary care and public health initiatives. Additionally, the government has focused on enhancing crisis preparedness and ensuring that the healthcare system can manage future public health emergencies.

5. Who has access to the healthcare system as a patient on the one side and as a medical service provider/supplier of medical goods on the other side? What are the conditions of admission?

All residents of Norway, including citizens and individuals with a valid residence permit, are covered by the National Insurance Scheme, and thus have access to the public healthcare system, regardless of health status, income, age, gender, geographic location, etc. This includes primary care, specialist services, and hospital treatment. Foreigners who are employed and pay taxes in Norway also have access to the public healthcare services.

In terms of healthcare providers, we note that public funding and reimbursement are available to healthcare providers who are part of the National Insurance Scheme. This includes GPs, specialists, and hospitals that have agreements with the RHAs. To qualify for this, providers must comply with national standards and regulations, and they are often required to negotiate service agreements and reimbursement rates with the government or relevant health

authorities. Such negotiations are typically conducted through representative associations, e.g. Norwegian Medical Association, rather than with each provider individually.

Suppliers of medical goods, such as pharmaceuticals and medical devices, must obtain approval from the Norwegian Medicines Agency for their products to be eligible for reimbursement under the National Insurance Scheme.

Norwegian residents who need medical treatment while abroad are covered under certain conditions, such as emergency care or pre-planned treatment in another EEA country. Although the National Insurance Scheme may cover these costs, prior approval is often required for planned treatments.

Access to the healthcare system is primarily based on residency and tax contributions, rather than on nationality. However, non-residents are entitled to receive necessary emergency healthcare. This includes tourists and visitors who may need urgent medical attention. As a result, emergency healthcare services are accessible to everyone, regardless of their insurance or residence status.

In terms of reimbursement, non-residents on a visitor's visa from countries without a healthcare agreement with Norway are not entitled to reimbursement of expenses for medical treatment by the Norwegian state. In such case, when visiting Norway on a visitor's visa, non-residents need to have health insurance to cover the healthcare expenses. Otherwise, non-residents will have to cover the expenses themselves. However, if in need of urgent medical care, the health services cannot reject non-residents, even if they are unable to pay for the services.

HEALTH INSURANCE FINANCING AND COVERAGE

6. How are health insurance carriers financed? How are premiums determined?

The National Insurance Scheme is tax-funded. In practice, funds for the operation of the public healthcare are allocated through the national budget, where the government proposes annual allocations that are approved by the Parliament.

This means that the population contributes according to income, regardless of the individual's likelihood of illness. For treatment outside a hospital by a doctor (a GP or a specialist), a psychologist or physiotherapist, as well as for prescriptions of certain drugs and for transportation expenses in connection with examination or treatment, the main rule is that the patient must pay a share of the cost (out-of-pocket expenses). The remaining costs are paid by the municipality, the RHAs and/or the National Insurance Scheme.

Private healthcare insurance is *rarely* subscribed by private individuals since all residents are entitled to healthcare through the public healthcare system, see also Q5. However, an increasing number of employers choose to provide private insurance schemes as a benefit to their employees.[1] The primary reason for this is that private health insurance can provide employees quicker access to medical evaluations and treatments compared to the public healthcare system, but also that the employees can receive treatment from private practitioners and private hospitals that are not part of the public healthcare system. This may not only

[1] In 2024, a report made by Samfunnsøkonomisk Analyse stated that 800 000 Norwegian residents were covered by a private health insurance, of which 8 of 9 of these persons were covered through a scheme covered by its employer. https://cdn.sanity.io/files/4yzykl1i/production/c8121907574a28c3069db06ff860fc1cda832bcc.pdf/R26-2024%20Privat%20helseforsikring%20-%20Nyttig%20eller%20unyttig.pdf

facilitate reduced sick leave and a faster recovery but it is also associated with employee satisfaction and is considered to be a competitive advantage.

The premiums for private insurance coverage are set on the basis of traditional insurance risk principles, taking into account factors such as age, health status, desired coverage and lifestyle. As the number of such insurances are generally limited for the reasons set out above, the premium settings have not been subject to comprehensive legal scrutiny by the courts. However, the general requirements applicable to insurance carriers must be respected.

7. How is coverage of medical services by health insurance carriers regulated? Are there differences in coverage for in-person medical appointments and telemedicine appointments?

Medical services covered by health insurance carriers is regulated by the existing insurance contract. All carriers must in addition comply with the strict rules applicable to insurance companies, primarily the Norwegian Insurance Activities Act. However, this Act does not impose rules concerning the coverage of medical services specifically.

HOSPITAL SECTOR

8. How are services provided by hospitals in the stationary (inpatient) and ambulatory (outpatient) settings financed and reimbursed?

Norwegian stationary hospitals are primarily funded through a combination of state allocations and activity-based financing (all funded through the national budget):

- *State allocations*: The majority of funding comes from annual state allocations, known as the basic grant. This funding is intended to guarantee equitable healthcare services across the country.
- *Activity-based financing*: Hospitals also receive funding based on the volume and type of services they provide. This system, known as activity-based financing, incentivises hospitals to increase efficiency and productivity, as a portion of their funding is linked to the number of treatments and procedures they perform.
- *Additional funding models*: Recent changes have introduced new models for calculating interest on hospital loans and have reduced equity requirements for investments, aiming to better support hospital growth and financial stability.

These funding mechanisms collaborate to ensure that hospitals can provide necessary medical services while maintaining financial health and operational efficiency.

The ambulatory health services, also known as outpatient services, are primarily funded through the public healthcare system. Patients pay a deductible for many services: see also Q1 above. The National Insurance Scheme covers a significant portion of healthcare costs, and the Health Economics Administration manages reimbursement schemes for specific expenses. Additionally, municipalities and RHAs contribute to the funding of these services.

9. How are the prices of such services determined? How is economic efficiency controlled?

In Norway, the government closely monitors the national healthcare costs. The fact that public hospitals are partly financed on the basis of activity, is believed to promote efficiency and fair compensation. Moreover, hospitals are subject to regular audits and public reports to ensure efficient use of funds.

The government is currently assessing the implementation of Technical Calculation Committees, which will review and adjust hospital financing models to reflect actual costs and demographic changes. Other policy reforms are also being considered, such as reducing equity requirements for investments and adjusting interest rates on hospital loans, to improve financial management.

We further note, that DRG system (Diagnosis Related Groups) is utilised in the ISF scheme (*Innsatsstyrt finansiering*/the activity-based financing scheme), where hospitals and healthcare institutions receive financial support based on the amount and type of healthcare services they provide. Each DRG group has a specific cost weight that reflects the resource usage for the respective treatment or diagnosis, ensuring that the funding aligns with the actual activity.

HEALTHCARE PROVIDERS IN PRIVATE PRACTICE

10. How are services provided by physicians, therapists, laboratories and other service providers financed and reimbursed?

Private healthcare providers in Norway are primarily financed and reimbursed as follows:

- *User payments*: Many private healthcare services are funded directly by patients, who pay out of pocket for treatments and consultations. This includes services such as MRIs, X-rays, and various surgical procedures.
- *Private health insurance*: A significant portion of funding comes from private health insurance schemes: see also Q6 above.
- *Agreements with public sector*: Some private healthcare providers have agreements with public health authorities to deliver specific services, and parts of their work is thus paid by the state or municipalities. Typically, these collaborations include services provided by cardiologists or dermatologists, rehabilitation services, mental health services, as well as surgical procedures. These collaborations aim to enhance the overall efficiency and accessibility of healthcare services in Norway.

11. How are the prices of such services determined? How is economic efficiency controlled?

In Norway, healthcare services provided by private practitioners are determined by market conditions and demand. When these services are delivered under agreements with the public sector, they are subject to strict public procurement regulations, which gives strong incentives to provide competitive prices.

PHARMACEUTICALS AND MEDICAL DEVICES

12. How are pharmaceuticals and medical devices financed and reimbursed?

In Norway, the financing and reimbursement of pharmaceuticals and medical devices are managed through a combination of public funding and out-of-pocket payments.

The majority of pharmaceutical costs are covered by the National Insurance Scheme. This scheme is funded by taxation and income-related contributions from both employers and employees. Patients may need to co-pay for certain pharmaceuticals. There are annual caps on patients' out-of-pocket expenses to protect against excessive costs.

Medical devices are also primarily funded through the National Insurance Scheme. The costs are either fully or partially covered, depending on the type of device and its necessity. The latter condition, 'necessity', refers to the importance of the medical device for diagnosing, treating, or managing a medical condition. Devices deemed essential for a patient's health and wellbeing are more likely to be fully covered, while those considered less critical may receive partial coverage.

Pharmaceuticals are reimbursed based on a positive list system. Only medicines that are included on this list are eligible for reimbursement. The list is maintained and updated by DMP. For the majority of outpatient prescription drugs, reimbursement is automatic if the drug is on the positive list. Patients typically pay a copayment, but the majority of the cost is covered by the National Insurance Scheme.

For drugs not included on the positive list, patients can apply for individual reimbursement through the Norwegian Health Economics Administration.

DMP is responsible for reimbursement decisions on behalf of the National Insurance Scheme.

Pharmaceuticals and medical devices used as part of the specialist medical services are financed by the four RHAs.

Before being reimbursed and publicly funded either by the RHAs or under the National Insurance Scheme, all new pharmaceuticals are subject to a Health Technology Assessment (HTA). Price is a decisive factor for cost-effectiveness and, therefore, the reimbursement decision, and the HTA is utilised in potential price negotiations with the holder of the marketing authorisation.

The RHAs have established a Decision Forum which utilises the HTA to decide if, and under which circumstances, a medicine will be used and reimbursed in the specialist care sector. The assessments also provide an input for price negotiations (see below).

For certain medications prescribed by the hospitals, the RHAs assume special financial responsibility, even when the treatment occurs outside of hospitals. This includes disease-modifying biological drugs for rheumatic disorders as well as some medications for treating multiple sclerosis (MS) and cancer.

13. How are the prices of pharmaceuticals and medical devices determined? How is economic efficiency controlled?

Norway has a statutory pricing policy for prescription-only medicines that are authorised for human use. The policy operates on a maximum price regulation and the stepped-price (*trinnpris*) regulation.

The DMP sets the maximum price for prescription-only medicines. Before entering the Norwegian market, the holder of a marketing authorisation for a prescription-only medicine must apply for a maximum price with DMP. The DMP then determines (1) the maximum pharmacy purchasing price (the price at the level of the wholesaler – PPP) and (2) the maximum pharmacy mark-up. The maximum pharmacy purchasing price together

with the maximum pharmacy mark-up form the maximum pharmacy retail price, ie, the consumer price (price set at the level of the pharmacy). The maximum pharmacy purchasing price is set as the mean of the three lowest prices for the product in a selection of European countries.

The set maximum prices are only a maximum, and discounts are allowed. Discounts should be given at the point of sale to the end user/patient.

The Norwegian Hospital Procurement Trust performs tenders and manages price negotiations for medicines reimbursed by the RHAs.

When a pharmaceutical product has lost its patent protection and is exposed to generic or biosimilar competition, the product becomes subject to the stepped-price model. This model was introduced in 2005 to reduce the costs incurred by the National Insurance Scheme and patients in relation to the use of generic medicines. Since August 2021, there has also been a stepped-price model for biosimilars. In the stepped-price model, the price of a generic or biosimilar is reduced stepwise at predefined rates.

Prices for over-the-counter (OTC) medicines are not regulated.

LITIGATION INVOLVING HEALTHCARE FINANCING AND REIMBURSEMENT

14. Please provide a high-level overview of major litigation topics and landmark cases regarding healthcare financing and reimbursement.

In Norway, litigation involving healthcare financing and reimbursement is limited. There was one case before the court of first instance in 2004 regarding decisions from DMP (then NoMA) on maximum prices. Three pharmaceutical companies claimed that decisions on maximum prices were invalid, but they did not succeed. Other litigation issues have been whether generics and biosimilars should be included on the substitution list.

Otherwise, there have been discussions regarding prioritisation, especially concerning expensive treatments for rare diseases, but these discussions have not ended in litigation.

RECENT DEVELOPMENTS AND TRENDS

15. What are the recent developments and trends for the next few years? Please outline any unresolved issues, proposed changes, or trends for healthcare financing and reimbursement and briefly indicate how these may foreseeably affect the medical sector in the near future.

Proposed changes for healthcare financing

In the 2025 national budget, the Norwegian government has proposed a substantial increase in operating allocations for hospitals compared to the 2024 budget. This is intended to ensure that hospitals receive an allocation to cover the actual rise in costs due to demographic changes and will help to reduce waiting times.

Starting in 2025, the financing mechanisms will be changed so that the increase in activity can be realized at 100 per cent of the average treatment cost, instead of 80 per cent which has been the case for many years. Additionally, the share of initiative-based funding will be reduced, and the government will change the financing mechanisms for hospital investments by lowering

the equity requirement and improving interest rates on loans. In 2025, special subsidies will be granted to the Northern Regional Health Authority.

Unresolved issues

- *Sustainability of funding:* Securing the long-term sustainability of healthcare funding remains a challenge, especially with an ageing population and increasing healthcare demands which may challenge existing financing models. At the same time, innovation in treatments can lead to improved health outcomes but also require new approaches to financing and reimbursement.
- *Equity in access:* Addressing disparities in healthcare access, especially in rural areas, continues to be a priority. The evolving financing models aim to balance the allocation of resources more effectively.
- *New technology:* The increased use of technology can improve efficiency, but it also requires investments and adaptations.
- *Reimbursement schemes:* It is necessary to consider how reimbursement schemes can be adapted to meet future challenges, including how to manage expensive new treatments.
- *Integrated patient pathways:* There is an increased focus on ensuring integrated patient pathways, where patients receive continuous and coordinated care throughout the different levels of the healthcare system.
- *Prevention and public health:* Greater emphasis on preventive measures and public health can help to reduce the need for costly treatments and alleviate the burden on the healthcare system.

Impact on the medical sector

Healthcare providers may need to adapt to new reimbursement models and reporting requirements. The shift to bundled payments and larger basic grants can lead to more stable funding, but it may also require adjustments in both service delivery and financial planning.

Patients could benefit from more integrated and personalised care options, especially with the expansion of telemedicine and the patient-administered treatments. However, ensuring equal access to these services will be important.