

Overview

Norway has universal health coverage funded primarily by general taxes and payroll contributions shared by employers and employees. Enrollment is automatic for legal residents. Covered services include primary care, mental health care, and hospital care, as well as some outpatient prescription drugs. Municipalities are responsible for primary health care, while the national government is responsible for hospital and specialty care services through the state-owned regional health authorities.

Per capita health care spending is among the highest in Europe.¹ Although the health system is well-resourced overall, there are persistent challenges related to workforce shortages and coordination. In March 2024, the government adopted the National Health and Cooperation Plan 2024–27 (*Nasjonal helse- og samhandlingsplan 2024–27*), which outlined objectives for future reforms, including workforce development, improved care coordination and integration, and shorter wait times.²

Coverage and Access

Background and History

Political and social movements began advocating for universal social and health care insurance around 1900, and the first mandatory health insurance, which covered employees and their families, came into force in 1909. The coverage was twofold: health care and a guaranteed basic income in the event of income loss due to ill health. Membership was mandatory for low-income employees, while others could opt in. In 1956, the system was converted into a universal and mandatory right for all citizens.

The health care system is founded on the principles of universal access, decentralization, and free choice of provider.³ Norway's universal health and social insurance coverage, known as the National Insurance Scheme (NIS) or *Folketrygd*, is regulated by the 1997 National Insurance Act and the 1999 Patients' Rights Act.

HEALTH SYSTEM BY THE NUMBERS

8.1%

Health care spending
as a percent of GDP

83 years

Life expectancy at birth

100%

Public insurance coverage

The Role of Public Health Insurance

Health coverage is automatic for all legal residents and is funded by two main sources: the general tax system and out-of-pocket payments by households. It covers the following services:

- Preventive care⁴
- Inpatient care⁵
- Outpatient care
- Maternity care⁶
- Primary care
- Pharmaceuticals
- Dental care
- Eye care
- Mental health care⁷
- Palliative care⁸
- Long-term care⁹
- Rehabilitative care (cost-sharing caps apply)¹⁰
- Home visits¹¹
- Assistive devices.¹²

Through reciprocal agreements, European Union (E.U.) residents have the same access to health services as in their home countries. Visitors from most other countries are charged in full. Undocumented adult immigrants only have access to emergency acute care, but undocumented children receive the same care as citizens.¹³

Safety Nets

There are several safety nets in place to ensure equitable health care access for all legal residents. General practitioner (GP) visits, outpatient specialist visits, and prescription drugs, for instance, are free for children under age 16, while dental care is free for those aged 18 and under, and reduced for those ages 19 to 28 (see *The Role of Public Health Insurance*).¹⁴ The government has pledged to make GP visits free for children ages 16 to 17 in 2026.¹⁵

The Norwegian Health Economics Administration (Helseøkonomiforvaltningen, or Helfo), meanwhile, provides subsidies for patients with specific health needs or diseases that require frequent or specialized care.¹⁶

In 2021, an annual cost-sharing cap was introduced to protect the population from excessive health care spending. Fees that count toward this cap include services such as consultations, treatments, and imaging and services provided by therapists (such as physiotherapists and psychologists) who have agreements to supply services within the public sector.¹⁷

Other Safety Net Mechanisms

- Recipients of the minimum state pension (*minste pensjonsnivå/ minstepensjonister*), which amounts to about NOK 288,237¹⁸ (USD 26,798) per year, and patients with approved occupational injuries are exempt from paying user fees for blue prescriptions (which are generally for long-term chronic conditions).^{19,20}
- People with certain communicable diseases, including HIV/AIDS, and patients with work-related injuries receive free medical treatment for their conditions.²¹

- Patients who regularly incur additional expenses because of permanent illness, injury, or disability may apply for an additional cash transfer, known as basic benefits, of NOK 752–3,744 (USD 70–348) per month.²²
- People whose functional capacity is significantly and permanently (for more than two years) impaired owing to an injury, bodily defect, or other health issue are entitled to receive financial support for assistive devices, such as wheelchairs, under the NIS.²³

The Role of Private Health Insurance

The majority of private health insurance policies (91%) are employer-sponsored, with employers fully covering the cost.²⁴

Private health insurance offers additional coverage beyond the standard public system. Voluntary health insurance (VHI) is for those joining the public NIS voluntarily — for example, people who are not automatically eligible. This may be because they are staying in the country for more than three months but not working or because they are a Norwegian resident temporarily living abroad.²⁵

Most private patients receive treatment in publicly funded hospitals: since 2023, patients can only seek care at public hospitals or from private providers with a public tender agreement (a formal procurement contract issued by public health care authorities).²⁶

Private health insurance and VHI typically cover services such as dental care, pharmaceuticals, and long-term care, which are typically financed through out-of-pocket contributions.²⁷ To access specialist care through the private sector, patients must first receive a referral from their GP or another specialist.²⁸

The Role of Government

Responsibility for health care is divided between national, regional, and municipal governments.

The national government plays an active role and is responsible for providing equal access to care regardless of socioeconomic status or geographical location.²⁹

“In general, everyone has equal access to publicly funded health care services,” says Kjetil Telle, executive director of the division of health services at the Norwegian Institute of Public Health. “They are generally high-quality [services].”

National Government (the Ministry of Health and Care Services)

The Ministry of Health and Care Services (*Helse- og omsorgsdepartementet*, or HOD) is the central government body responsible for the overall planning and regulation of health care services.³⁰ It sets national health policy goals and develops the National Health and Hospital Plan, which is updated every four years.³¹ The Norwegian Directorate of Health (*Helsedirektoratet*) reports to the HOD, implements its policies, and is responsible for developing national clinical guidelines and licensing health personnel.³² The Ministry of Digitalisation and Public Governance (*Digitaliserings- og forvaltningsdepartementet*) leads digitalization efforts in health care.³³

Regional Health Authorities

The four regional health authorities (*Regionalt helseforetak*, or RHF) are responsible for specialist care. The RHF manage 20 hospital trusts and finance and oversee hospital services.³⁴ They work to ensure that specialized care aligns with national policies while addressing regional needs.³⁵

Municipalities

Municipalities play a role in the delivery of primary care, rehabilitative care, nursing services, and public health initiatives — the last, often in cooperation with Norway's counties, which also help oversee the coordination of care. Counties serve as administrative appeal bodies for municipal decisions concerning health services.³⁶

Municipalities organize and provide essential services, which are funded through a combination of municipal taxes, central government grants, NIS contributions, and patient copayments. Municipalities also manage programs focused on disease prevention, mental health, and social well-being.³⁷

Other Support Organizations

Several national agencies support the HOD in policy implementation and health care delivery:

- The Norwegian Board of Health Supervision (Helsetilsynet) is the government's regional supervisory authority at the county level.³⁸
- The Norwegian Institute of Public Health (Folkehelseinstituttet) provides research, data, and analysis on public health issues.³⁹
- Helfo is responsible for making direct payments to providers and setting reimbursement levels.⁴⁰
- The Health and Social Services Ombudsman (*Pasient-og brukerombudet*) in each county acts as a patient advocacy agency, helping patients and clients get the treatment they need.⁴¹
- The Norwegian Medicines Agency (Direktoratet for medisinske produkter, or NOMA) is responsible for ensuring the efficacy, quality, and safety of medicines and for administering and enforcing medical device regulations.⁴²

Integration and Care Coordination

Steps have been taken to coordinate care and integrate the delivery system, particularly for elderly people and patients with chronic conditions. From 2018 to 2023, multidisciplinary primary care teams, including nurses and health secretaries, were piloted to strengthen follow-up and monitoring for patients with chronic conditions.⁴³ A 2025 evaluation of the program identified notable improvements, including more consultations per patient, higher rates of home visits, annual diabetes check-ups, and coordinated meetings between GPs and other health care providers.⁴⁴

Hospitals now play a more active role in coordinating smooth patient transitions after discharge. To do this, they use detailed discharge checklists to ensure continuity of care and work closely with municipalities to organize post-discharge follow-ups, improving integration and support across health care settings.⁴⁵

Municipalities balance hospital care and long-term care for the elderly, allocating resources based on assessed needs.⁴⁶

Since 2013, the National Welfare Technology Programme (Nasjonal velferdsteknologiprogram) has promoted large-scale implementation of integrated care solutions. Projects such as those led by the Regional Coordination Group for e-Health and Welfare Technology (Regional koordineringsgruppe e-helse og velferdsteknologi) in Agder have focused on integrating welfare technology into health services across 25 municipalities and hospitals (see *Health Care Technology*).⁴⁷

Health Care Communities (Helsefellesskap)

Established as part of the Health and Hospital Plan 2020–23, Health Care Communities seek to encourage collaboration between municipalities, hospital trusts, GPs, and patient representatives. They aim to ensure alignment between local and national priorities, improving care coordination and access to services.⁴⁸

Operations and Resources

Overview of the Delivery System

- **Primary care** is the first point of contact for patients, involving GPs, dentists, and pharmacists.
- **Secondary care** includes hospitals, outpatient clinics, and psychiatric services and is typically accessed through a GP referral.
- **Tertiary care** involves highly specialized, complex treatments and care and is often provided at larger hospitals.

Primary health care is delivered at the municipal level, while secondary or specialized care is delivered at the county level.⁴⁹

Patients make copayments directly to care providers at each visit. The process is fully electronic and automated, and the patient and provider are alerted if the annual safety net cap is reached.

Payment mechanisms are structured to include a mix of capitation, fee-for-service, fixed-budget, and outcome-based payments. Capitation payments are based on a fixed rate per patient and consider a number of characteristics, such as age, gender, and previous health service use.⁵⁰

GPs: Payments consist of capitation payments (based on patient demographics, such as age and health history), fee-for-service payments from Helfo, and patient copayments. Capitation payments account for about 25 percent of GP income. GPs with fewer than 1,000 patients receive additional support funding.

Specialist and acute hospitals: Payments include fee-for-service, case-based, and fixed-budget payments. Since 2022, a new system based on patient outcomes has replaced quality-based financing for hospitals, with regularly updated outcome indicators.

Hospital outpatient services: Payments are a combination of fee-for-service, case-based, fixed-budget, and outcome-based payments, as well as copayments.

Dentists and pharmacies: Providers are mainly compensated through fee-for-service models.

Specialist care: Providers are mostly funded through global budgets, with elements of case-based funding incorporated.

Primary Care

Primary care services are organized and provided by municipalities, which are responsible for care delivered by GPs, health centers, nursing homes, home-based care providers, and specialty service providers, such as physiotherapists, occupational therapists, and substance abuse care providers.

GPs are the first point of contact for patients seeking health care services. They handle diagnoses, treatments, and prescriptions and coordinate referrals to specialists or hospitals for specialized treatments. All residents are entitled to a GP, and patients have the freedom to choose their own, but there are shortages in some municipalities. In 2023, there were 498 doctors for every 100,000 people, higher than the average of 360 among high-income countries.⁵¹ Municipalities work to ensure that residents have access to medical care, even outside regular working hours.⁵²

Municipalities contract with individual GPs, who are mostly self-employed.⁵³ A minority of GPs (18%) are employed by municipalities, with about half receiving a fixed salary and the other half receiving a fixed salary with additional forms of remuneration.⁵⁴ Average monthly earnings for GPs in municipal administration are NOK 93,130 (USD 8,658).⁵⁵

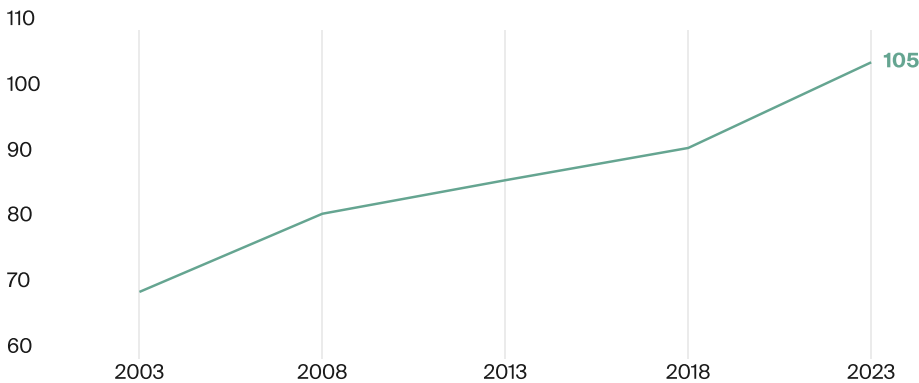
Primary care is mainly financed through municipal taxes, block grants from the central government, and grants for specific initiatives. A significant portion of funding also comes from the NIS and patient copayments. This financing structure is designed to control costs while giving health care providers the flexibility to offer the most appropriate mix of services to meet patients' needs.⁵⁶

Over the past decade, reforms have sought to strengthen primary care by focusing on improving accessibility, coordination, and service integration.

Expansion of professional roles: Ongoing reforms are promoting task-sharing in primary care, with nonmedical professionals, such as nurses and physiotherapists, now authorized to oversee follow-up care for patients with chronic conditions. This shift reflects a growing trend toward greater collaboration and expanded roles for health care providers beyond GPs.

Improved access to care: Access to primary care has improved, with 33 percent of patients seeing their GPs on the same day and 40 percent within four days. Over 50 percent report easy access to out-of-hours care, which every municipality has to offer.^{57,58} However, GP shortages in certain regions, particularly rural areas, can affect timely access to care.⁵⁹

Number of GPs per 100,000 People, 2003–23



Source: The Global Health Observatory, [Medical doctor: generalist medical practitioners \(number\)](#), distributed by World Health Organization, accessed May 19, 2025. Note: Numbers calculated using the World Bank's population data (World Bank Open Data, [Population, total – Norway](#), distributed by World Bank Group, accessed October 28, 2025).

Outpatient/Specialist Care

Secondary care is mainly provided through public hospital outpatient departments, known as polyclinics, which offer somatic care (focused on the mind–body connection), mental health services, and alcohol and substance abuse treatment. These departments also provide laboratory and radiology services.

“A key strength of the system is the explicit prioritization process for medications and procedures, particularly in specialist services,” says Kjetil Telle, executive director of the division of health services at the Norwegian Institute of Public Health. “These ensure evidence-based and cost-effective treatments.”

In addition to hospital-based services, self-employed specialists, such as obstetricians and internal medicine specialists, provide about 25 percent of specialist outpatient consultations. They work under contract with RHF and are prevalent in somatic care fields, such as ophthalmology, otolaryngology (ear, nose, and throat), and dermatology, and in mental health care.⁶⁰ In 2023, there were 212 specialist medical practitioners for every 100,000 people, compared with 236 across Organisation for Economic Co-operation and Development countries in 2021.⁶¹

Hospital-based specialists are salaried. The estimated total pay for a doctor is NOK 1,061,147 (USD 98,656) per year in the Oslo area, with an average salary of NOK 936,000 (USD 87,021) per year.⁶²

In principle, patients can choose their own specialists. In practice, however, access to secondary care can vary by region, with specialists more likely to be oversubscribed in the Southeastern RHF. In rural and remote areas, community hospitals (*sykestue*) provide care that doesn't require hospital admission, as well as posthospital care, and they determine whether a patient needs hospitalization. These hospitals may also work with self-employed specialists or act as local departments for larger hospitals.⁶³

Over the past decade, the structure of secondary care has remained relatively stable, with a consistent reliance on polyclinics and community hospitals in rural areas.

Physician Education and the Workforce

Four public universities provide medical degrees. There are no tuition fees, even for international students (the only cost is a mandatory student union fee, which covers various services and activities while at university).⁶⁴

In 2023, there were 10.8 medical graduates for every 100,000 people,⁶⁵ compared with 15.7 in the E.U.⁶⁶ A high proportion of students pursue their medical education abroad, owing to a limited number of medical school slots available domestically.⁶⁷ From 2013 to 2021, the number of applicants trained abroad increased by 46 percent, while the number trained in Norway grew by just 5 percent.

However, 87 percent of foreign-trained applicants for junior doctor positions in Norway are Norwegian citizens returning home to practice once qualified.⁶⁸ Many of these students return with an average level of debt that's higher than it would have been if they had stayed in Norway to study.⁶⁹

The health care system is supported by a strong medical workforce, with one of the highest densities of practicing doctors and nurses among European Economic Area countries.⁷⁰ However, GP shortages are a concern in certain municipalities, and nursing turnover rates are high, exceeding 20 percent annually.⁷¹

Despite these challenges, recruitment programs launched in 2023 and reforms to GP financing have reduced wait times and increased GP availability in municipalities. A further NOK 115 million (USD 11.3 million) has been pledged in the 2026 National Budget to improve GP services, including adding more nurses to GP surgeries, and piloting online GP appointments (see *Health Care Innovation*).⁷²

Number of Medical Graduates per 100,000 People, 2021



Source: *Health at a Glance 2023* (Organisation for Economic Co-operation and Development, 2023), 191.

Hospitals

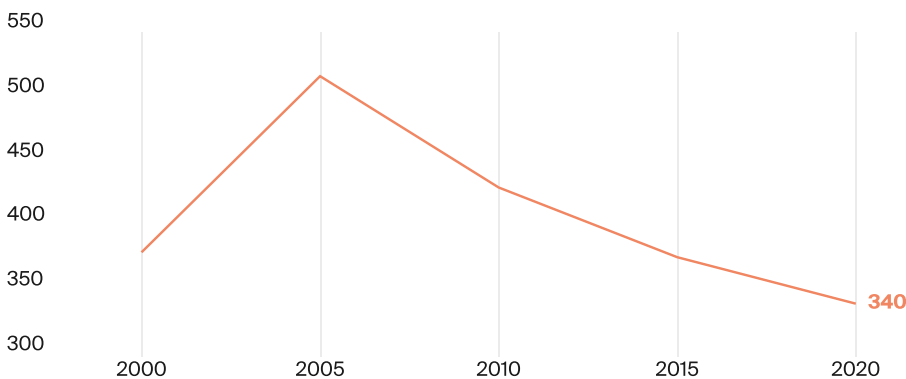
The health care system mainly consists of public hospitals, which are funded and owned by the state. These hospitals are managed by RHF, each of which oversees a set of hospital trusts within its region. A small number of hospitals are privately owned⁷³ and don't typically offer acute care or a full range of services.⁷⁴

Most public hospitals are concentrated in the highly populated southeastern region. Access to health care in sparsely populated northern and rural areas, however, can be challenging. For instance, in the county of Nordland, hospitals within a single trust can be more than 500 kilometers apart.⁷⁵

The number of hospital beds has been steadily declining over the past 20 years, stabilizing at 340 beds for every 100,000 people in 2020 and 2021, compared to 537 across high-income countries in 2020.⁷⁶ Still, the number of practicing nurses and midwives has increased in the years that have followed, reaching 1,651 for every 100,000 people in 2023.⁷⁷

Patients need a GP referral to acute care services. In specific cases, such as accidents or a suspected heart attack, patients can contact emergency medical services.⁷⁸ Patients can choose a hospital for elective services but not for emergency care.

Number of Hospital Beds per 100,000 People, 2000–20



Source: The Global Health Observatory, [Hospital beds \(per 10,000 population\)](#), distributed by World Health Organization, accessed October 28, 2025.

Mental Health Care

In Norway, mental health care is provided through both primary care settings and hospitals, with municipalities responsible for organizing services. GPs serve as the first point of contact for adults, addressing mild-to-moderate conditions and managing follow-up care for more severe cases.⁷⁹

In 2020, there were 22.8 psychiatrists for every 100,000 people. This compares to 19.5 for every 100,000 in Sweden and 20.2 for every 100,000 in Finland. Overall, there were 247.2 mental health professionals for every 100,000 people.⁸⁰ For specialized care, GPs may refer patients either to private psychologists and psychiatrists or to community mental health centers, which provide acute care services (inpatient, outpatient, and day care) and rehabilitation services while supervising and supporting primary care.⁸¹ These centers, which are dispersed throughout the country, often have psychiatric outreach teams. Shortages of mental health professionals, however, can limit timely access, especially in rural regions.⁸²

In 2025, the government exempted additional mental health services for young adults from copayments as part of its larger Mental Health Escalation Plan (2023–33) (Opptappingsplan for psykisk helse) (see *Health Care Innovation*). Outpatient psychiatric care for those age 26 and under, along with outpatient addiction treatment provided by the Psychiatric Youth Team for patients under age 30, will not require additional charges. Those under age 16 (or 18 if they receive psychotherapeutic treatment), as well as pensioners with minimal income, are exempt from any user fees.⁸³

Long-Term Care and Social Support

Long-term care accounts for about 30 percent of total health spending. It's provided in three main settings — patients' homes, nursing homes, and sheltered homes — all of which are run by municipalities (which may contract with private providers).⁸⁴ End-of-life care for terminally ill patients is often provided by health care professionals in advanced-care wards within nursing home settings.⁸⁵

Service eligibility is needs-based and determined by municipal criteria in cooperation with GPs and home nurses.⁸⁶ Most long-term care recipients (age 80 and over) receive care at home and remain there, with the remainder residing in nursing homes.⁸⁷

Some people experience challenges in accessing long-term care. One challenge is the long wait times for care services, particularly for long-term institutional care, where the wait can exceed 16 days. Larger municipalities tend to have longer waits than smaller ones. Municipalities face financial pressures in funding care — especially nursing homes, which are expensive and often considered a last resort.⁸⁸

For long-term nursing home stays, municipalities may charge an income-dependent user fee equal to about 80 percent of residents' after-tax income, capped at the actual cost of the service. For home-based care, municipalities can impose an income-dependent user fee for practical home-based care, while home nursing services are provided free of charge.⁸⁹

Cost and Affordability

Health Care Spending Overview

In 2022, health expenditure accounted for 8.1 percent of gross domestic product (GDP), or NOK 83,084 (USD 7,724) per person.⁹⁰ This compares to 8.2 percent across high-income countries.⁹¹ Public sources account for most health expenditure (86%).⁹²

The social security law serves as a framework for the NIS, which provides various benefits and payments to individuals. Individual contributions are 11 percent for self-employed people and 7.8 percent for other employees.⁹³ The employer's contribution is 14.1 percent, which can be reduced if it operates in sparsely populated locations or engages in certain types of activities.^{94,95,96}

The NIS accounted for 35 percent of the national budget in 2018, or NOK 470 billion (USD 45 billion).⁹⁷ Of this, enrollees and employers funded 67 percent, while the state and others funded the remaining third.⁹⁸

Health Care Spending as a Percentage of GDP, 2022



Source: The Global Health Observatory [Current health expenditure \(CHE\) as percentage of gross domestic product \(GDP\)](#), distributed by World Health Organization, accessed October 28, 2025.

Pharmaceutical Spending

Pharmaceuticals accounted for 8.7 percent of the total health care budget in 2022, with average spend per capita totaling USD 650.⁹⁹ This is lower than other high-income countries, such as Germany (USD 1,366), Switzerland (USD 960), and Canada (USD 1,037¹⁰⁰).¹⁰¹

There have been a number of measures to contain pharmaceutical costs.¹⁰² NOMA is responsible for assessing the cost-effectiveness of prescription-only medicines and setting maximum prices. It sets a maximum price at the pharmacy purchase price level for prescription-only medicines before market entry. It also determines which medications to reimburse for outpatients.

This policy was put into practice by the maximum price regulation and the stepped-price (*trinnpris*) regulation.¹⁰³ Introduced in 2005 for generic medicines and expanded to biosimilars in 2021, this model reduces pharmaceutical prices in stages at predefined rates once patent protection ends. It's designed to encourage competition and lower costs for the NIS and patients.

Cost Sharing and Out-of-Pocket Spending

In Norway, inpatient care and long-term, home-based nursing care are fully covered.¹⁰⁴ Most people do not require private health insurance, but some areas of health care require patient copayments, which are set nationally.¹⁰⁵

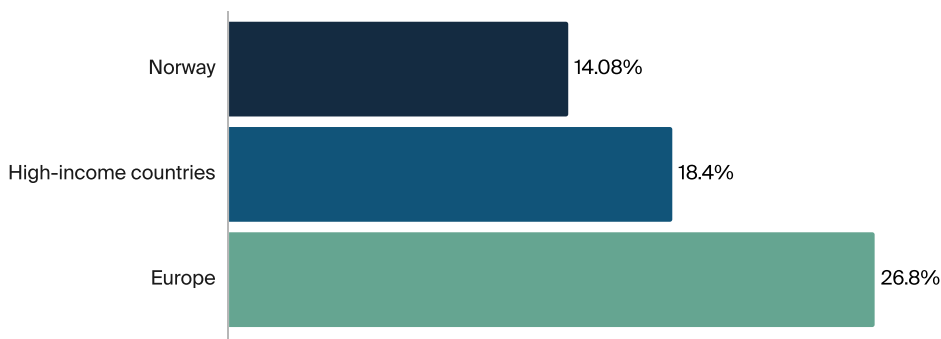
In 2022, out-of-pocket payments accounted for 14 percent of total health care spending.¹⁰⁶ Of those payments:

- Dental care constituted the largest portion, 25 percent.
- Pharmaceuticals accounted for 24 percent.
- Outpatient medical care accounted for 19 percent, reflecting the cost sharing required for consultations and treatments outside hospital settings.
- Long-term care accounted for 16 percent, indicating that while some services in this category are subsidized, patients still bear a portion of the cost.
- Other health-related services contributed 13 percent.¹⁰⁷

To ensure equity in health care access, exceptions are applied to certain diseases and marginalized population groups. An annual cost-sharing cap has been in place since 2021 to protect people from excessive costs. User fees for services such as consultations, treatments, imaging, and public-sector physiotherapy and psychology services count toward the cap.¹⁰⁸

The cap is managed through an exemption card (*frikort for helsetjenester*), which ensures that patients don't have to pay user fees for the remainder of the calendar year once their annual expenses exceed a government-set threshold.¹⁰⁹

Percentage of Health Care Spending That Is Out of Pocket, 2021



Source: Institute for Health Metrics and Evaluation, *Financing Global Health*, distributed by IHME, accessed October 28, 2025, <https://vizhub.healthdata.org/fgh/>.

How Are Costs Contained?

The central government sets an overall annual health budget, and municipalities and RHF are responsible for maintaining their own budgets. In 2023, the state spent about NOK 190 billion on private specialist health services. This represents a 5 percent increase over the previous year.¹¹⁰ Private providers are contracted through tender agreements, and the price of service is one of the criteria.

Before a health technology is introduced, NOMA conducts a health technology assessment to examine whether the potential benefits of treatment are in reasonable balance with its costs. Typically, the assessments include clinical effectiveness, safety, and cost-effectiveness.¹¹¹

Quality and Outcomes

Addressing Health Inequities

Aside from GP shortages in rural areas, which sometimes affect timely access to care, health inequities primarily stem from socioeconomic status and education.¹²¹ For example, women from higher socioeconomic backgrounds live 3.5 to 5.5 years longer than those from lower socioeconomic backgrounds, while the difference is even greater for men at 5 to 7.3 years.¹²²

Inequities in health are influenced by broader social factors, such as income, employment, and living conditions. These inequities predominantly affect immigrants, people with lower levels of education, and other marginalized groups. For instance, people who have attended higher education live five to six years longer than those with lower education levels, as they often benefit from healthier lifestyles and better access to health care.¹²³

Efforts to reduce these health inequities include the Public Health Act (2012), which makes the reduction of health inequities a central element of public health work at all levels of government. The law mandates that local governments consider the possible health impacts of their planning and policies.¹²⁴

Unmet medical needs in Norway are among the lowest in Europe, affecting just 0.9 percent of the population in 2020. This compares to 1.2 percent in both Denmark and Sweden.¹²⁵ Income-based disparities (income inequities) are narrower than in other Nordic countries as well. However, unmet dental care needs are common, particularly among lower-income groups.¹²⁶

The merging of out-of-pocket caps in 2021 lowered costs for patients with high out-of-pocket spending, and exemptions for critical services improved access for people on lower incomes.¹²⁷

Innovation and Reform

Health Care Innovation

The government is proposing to spend NOK 65 million (USD 6.4 million) of the 2026 National Budget on piloting online GP services. In addition, NOK 50 million (USD 4.9 million) was pledged to add more nurses to GP surgeries, to improve access for patients.¹²⁸

There have also been changes designed to make the health system more person-centered:¹²⁹

- By 2022, 18 of 19 planned Health Care Communities had been established to enhance care coordination between primary and specialist health care, focusing on patients who are frail and elderly, patients with multiple morbidities, children, and mental health care.
- The Mental Health Escalation Plan (2023–33) prioritizes access to community-based and specialized mental health care.

HEALTH OUTCOMES BY THE NUMBERS

Life expectancy in 2021 was **83 years (82 for men and 84 for women)**.¹¹²

The top three causes of death in 2021 were:

- Ischemic heart disease: **98 deaths per 100,000 people**
- Alzheimer's disease and other dementias: **56 deaths per 100,000 people**
- Chronic obstructive pulmonary disease: **45 deaths per 100,000 people**.¹¹³

The maternal mortality rate was **two deaths per 100,000 live births** in 2023 (compared with 10 per 100,000 in high-income countries).^{114,115}

The infant mortality rate was **two deaths per 1,000 live births** in 2022 (compared with six on average across Europe).¹¹⁶

In 2021, the share of the population with mental health disorders was **17 percent** (compared with 16% on average in high-income countries).¹¹⁷

In 2023, the suicide rate was **11.1 per 100,000 people**, compared with an average of 11.8 per 100,000 people across high-income countries.¹¹⁸

In 2023, guns were responsible for **1.1 death per 100,000**.¹¹⁹

19 percent of adults were affected by obesity in 2022 (compared with 16% globally).¹²⁰

- The Equalizing Social Health Differences Strategy (2023) aims to reduce social health inequities through intensified health promotion and disease prevention efforts.
- The National Health and Cooperation Plan 2024–27 aims to improve workforce development, reduce wait times, and continue health care digitalization.

Health Care Technology

Technology and digitalization are increasingly prominent in improving health outcomes. The Health Technology Scheme (*helseteknologiordningen*), managed by the Directorate of Health, was established in 2024 to help municipalities invest more in health technology and to encourage collaboration between municipalities on their digitalization efforts. The program is also very focused on strengthening the use of standards in health technology, such as system compatibility, security requirements, and safety guidelines.¹³⁰

The government has also prioritized digital health care solutions, such as telemedicine and e-health, to support integrated health care reforms and improve accessibility, efficiency, and patient care quality. Since 2020, municipalities have widely adopted the use of electronic referrals for hospital, e-prescription, and telemedicine services.¹³¹

Electronic health records are standard practice in hospitals and are readily accessible to patients via the national health portal, Helsenorge. Patients can use the website or app to see their full patient records and summary care records (Kjernejournal).¹³²

The National eHealth Strategy (Nasjonal e-helsestrategi for helse- og omsorgssektoren) is the health and care sector's joint strategy for digital transformation, aimed at improving services, increasing efficiency, and enhancing citizen participation.¹³³ Further efforts to enhance digital health care services include the establishment of the National Data Service (Helsedataservice) to streamline health research in the country through a single access point.¹³⁴

This profile reflects data as of February 2026. New or updated information may have become available since its release.

Notes

1. Ingrid S Saunes et al., *Norway: Health System Summary 2024*, (European Observatory on Health Systems and Policies and World Health Organization, 2024) <https://iris.who.int/bitstream/handle/10665/379919/97892289014380-eng.pdf?sequence=1>.
2. Saunes et al., *Norway: Health System Summary 2024*.
3. “The Norwegian health care system and pharmaceutical system,” Norwegian Medical Products Agency (*Direktoratet for medisinske produkter*), October 11, 2025, <https://www.dmp.no/en/about-us/the-norwegian-health-care-system-and-pharmaceutical-system>.
4. Joshua Wood, “15 expats talk about health insurance and healthcare in Norway,” *ExpatsExchange*, March 10, 2024, <https://www.expatsexchange.com/gd/4/85/Norway/Healthcare-in-Norway>.
5. Saunes et al., *Norway: Health System Summary 2024*.
6. “Pregnancy and childbirth in Norway,” Nordic Co-operation, accessed April 21, 2025, <https://www.norden.org/en/info-norden/pregnancy-and-childbirth-norway>.
7. “Mental healthcare for adults in Norway,” Helsenorge, accessed April 19, 2025, <https://www.helsenorge.no/en/psykisk-helse/mental-healthcare-for-adults-in-norway/>.
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