Pharmaceutical Health Information System

PHIS Hospital Pharma Report 2009

NORWAY

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PHIS

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PHIS Hospital Pharma Report

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- Norwegian Association of Pharmaceutical Manufacturers - LMI
- Norwegian Medicines Agency
- Norwegian Pharmacy Association
- Statistics Norway

Executive Summary

Most hospitals in Norway are public hospitals, funded and owned by the state. A small number of hospitals is privately owned. However, most private hospitals are funded by the public. A hospital is an institution for health care providing patient treatment by specialised staff and equipment.

In Norwegian hospitals the major pricing policy is procurement which is done for all public hospitals by the Drug Procurement Cooperation (LIS). LIS negotiates prices for medicines in the hospitals. These prices are considerably lower than maximum prices which the Norwegian Medicines Agency (NoMA) decides for all prescription-only-medicines on the Norwegian market.

In Norway hospital pharmaceuticals are covered by the hospital budget. There are pharmaceutical and therapeutic committees established by the hospitals which set up and decide on inclusion of medicines to the hospital pharmaceutical formulary for internal use. No country-wide medicines lists for in-patient care exist.

Hospitals spent NOK 3,500 / € 424 million on medicines in 2008 including 25% value added tax. The expenditure for medicines in hospitals will increase and probably be doubled in the next five years.

Interface management between the in-patient and out-patient sector in Norway exists with regard to specific medicines as hospitals pay for medicines that patients need after discharge of the hospital. These medicines include tumor necrosis factor (TNF) medicines and medicines for the treatment of Multiple Sclerosis (MS). The funding of these products was transferred from the budget of the National Insurance Scheme (NIS) to hospital budgets in 2006 and 2008 respectively. This was mainly due to the fact that some products in this field were financed by the NIS and some products were financed by the hospital. This created the economic incentive for hospitals to prescribe products funded by NIS. Also it was an aim to achieve more competition and lower prices.

Table of content

Acknowledgements III

Executive Summary V

Table of content VII

List of abbreviations IX

Introduction XI

1 Background 1

1.1 Definition and scope 1

1.2 Organisation 1

1.3 Funding 4

2 Pricing 6

2.1 Organisation 6

2.1.1 Framework 6

2.1.2 Hospital prices 6

2.2 Pricing policies 7

2.2.1 Procurement 7

2.2.2 Others 8

3 Reimbursement 9

3.1 National hospital reimbursement procedure 9

3.2 Hospital pharmaceutical formularies 9

4 Consumption of pharmaceuticals 10

5 Evaluation 11

5.1 Monitoring 11

5.2 Assessment 11

6 Interface management 12

7 Developments and outlook 12

8 References and data sources 13

List of tables and figures

Table 1.1: Norway – Key data on in-patient care, 2000 and 2004–2008 2
Table 1.2: Norway – Pharmaceuticals and active ingredients on market, 2000 and 2005–2009 ...3
Table 1.3: Norway – Health and pharmaceutical expenditure, 2000 and 2004–2008.....4
Table 4.1: Norway – Pharmaceutical consumption, 2000 and 2004–2008 10
Table 4.2: Norway – Top 10 pharmaceuticals by pharmaceutical expenditure and consumption 2007 in hospitals 10

List of abbreviations

AIFA	Agenzia Italiana del Farmaco / Italian Medicines Agency
ATC	Anatomic therapeutic chemical classification
BMG	Bundesministerium für Gesundheit / Austrian Federal Ministry of Health
DDD	Defined daily doses
DRG	Diagnosis-related group
EU	European Union
FHI	Folkehelseinstituttet / Norwegian Institute of Public Health
GÖG/ÖBIG	Gesundheit Österreich GmbH, Geschäftsbereich ÖBIG / Austrian Health Institute
GP	General practitioner
HE	Health expenditure
HOD	Helse- og omsorgsdepartementet / Norwegian Ministry of Health and Care Services
HOSHE	Health expenditure in hospitals
HOSPE	Pharmaceutical expenditure in hospitals
IHHII	International Healthcare and Health Insurance Institute (Bulgaria)
LIS	Legemiddelinnkjøpssamarbeid / Drug procurement cooperation
LMI	Legemiddelindustriforeningen / Norwegian Association of Pharmaceutical Manufacturers
Mio.	Million
MS	Multiple sclerosis
n.a.	not available
n.app.	not applicable
NIS	National Insurance Scheme
NOK	Norsk krone / Norwegian Krone
NoMA	Norwegian Medicines Agency / Statens legemiddelverk
NAF	Apotekforeningen / Norwegian Pharmacy Association
OPP	Out-of pocket payment
PE	Pharmaceutical expenditure

PHIS	Pharmaceutical Health Information System
POM	Prescription-only medicines
PPP	Pharmacy purchasing price
PTC	Pharmaceutical and therapeutic committee
RHA	Regional health authority
SSB	Statistisk sentralbyrå / Statistics Norway
SUKL	Statny Ustav pre Kontrlu Lieciv / State Institute for Drug Control (Slovakia)
THE	Total health expenditure
TNF	Tumor necrosis factor
TPE	Total pharmaceutical expenditure
VAT	Value Added Tax
WP	Work package

Introduction

PHIS research project

PHIS (Pharmaceutical Health Information System) is a research project commissioned under the call for proposals 2007 in the priority area “health information” of the European Commission, DG SANCO. It has been commissioned by the Executive Agency for Health and Consumers (EAHC) and co-funded by the Austrian Ministry of Health (BMG).

The PHIS project aims at increasing knowledge and exchange of information on pharmaceutical policies, in particular on pricing and reimbursement, in the European Union (EU) Member States, covering both the out-patient and the in-patient sector.

This will be done via different work packages (WP) resulting in the following deliverables:

- the PHIS Glossary with key terms related to pharmaceuticals,
- the PHIS Library offering country specific information on out-patient and in-patient pharmaceutical pricing and reimbursement for the EU Member States,
- the PHIS Indicators and the PHIS Database, containing major data for the developed indicators in the Member States,
- the PHIS Hospital Pharma Report with information on pharmaceutical policies in the in-patient sector in the EU Member States, including a price survey.

The PHIS project management is a consortium of the project leader Gesundheit Österreich GmbH, Geschäftsbereich Österreichisches Bundesinstitut für Gesundheitswesen / Austrian Health Institute (GÖG/ÖBIG), which is a research institute situated in Vienna, Austria, and four associated partners:

- the Italian Medicines Agency (AIFA),
- the International Healthcare and Health Insurance Institute (IHHII), Bulgaria,
- SOGETI Luxembourg SA., which is a services provider, and
- the State Institute for Drug Control (SUKL), Slovakia
- SUKL is the WP leader of Hospital Pharma.

Further key stakeholders are the PHIS Advisory Board covering EU Commission services and agencies and other international organisations, and the PHIS network, which comprises national representatives from competent authorities and further relevant institutions from the EU Member States and associated countries.

The PHIS project runs from September 2008 to April 2011 (32 months). Further information and all deliverables are made available at the PHIS project website http://phis.goeg.at.

PHIS Hospital Pharma

The aim of the work package “Hospital Pharma” is an in-depth investigation of the in-patient sector, as systematic knowledge of pharmaceutical policies in this sector has been rather poor.

The survey is divided in two phases:

- Phase 1: General survey

Country reports on pharmaceuticals in hospitals (“PHIS Hospital Pharma Reports”), designed to describe specific pharmaceutical policies in the in-patient sector in the EU Member States (spring 2009).

- Phase 2: Case studies

A specific survey, including a price survey, provided by means of case studies, in a limited number of hospitals in a few countries (autumn 2009).
The final PHIS Hospital Report, covering information from the general survey (phase 1) and the case studies (phase 2), is scheduled for February 2010.

Methodology of the general survey

The production of the country-specific PHIS Hospital Pharma Reports is based on three steps:

1. Development of a uniform PHIS Hospital Pharma Report Template

The PHIS Hospital Pharma Report Template offers a homogenous, very detailed structure for describing the pharmaceutical pricing and reimbursement system in the in-patient sector of a country. The Template was developed by SUKL, Slovakia (Work Package leader of Hospital Pharma) in coordination with GÖG/ÖBIG (PHIS project leader) and further members of the PHIS project management. It is based on literature and internet reviews as well as interviews with experts in the hospital sector in the EU Member States. Members of the PHIS network received the draft Template for feed-back, and had an opportunity to discuss and provide personal feed-back during a meeting.

2. Collecting information and data and drafting the PHIS Hospital Pharma Report

The country-specific PHIS Hospital Pharma Reports were written by members of the PHIS network. In order to get the needed information and data, hospital experts were contacted and involved in several countries. They provided information and data in written form and during telephone conservations and personal talks. In some countries the reports (or parts of it) were written by hospital experts. In several countries, the preparatory work for drafting the PHIS Hospital Pharma Reports also included study visits of the authors to hospitals and hospital pharmacies. Information on persons and institutions involved can be found in the “Acknowledgements” at the beginning of this PHIS Hospital Pharma Report and in section 8 “References and data sources”, listing “Literature and documents” (section 8.1) and “Contacts” (section 8.2).

3. Editorial process

The draft PHIS Hospital Pharma Reports were submitted to the project management for review, which was undertaken by SUKL, Slovakia (Work Package leader of Hospital Pharma) in coordination with GÖG/ÖBIG (PHIS project leader). The review focused on checking clarity and consistency in general and with regard to the outline of the Template and terminology (PHIS Glossary). In the course of the editorial process, the reviewers contacted the authors for providing feed-back on language and content, offering suggestions for re-phrasing and change and clarified open and/or misunderstanding points.

1 Background

1.1 Definition and scope

In Norway a hospital is an institution that provides medical, surgical or psychiatric care and treatment for the sick and the injured. They are mainly publicly owned. A few hospitals are privately owned by non-profit organisations; however, they are also funded by the public. This report refers to the publicly financed hospitals.

All hospitals provide in-patient care. Most of them also provide out-patient care in out-patient departments.

1.2 Organisation

The health care system in Norway is organised at three levels: the central State, the four regional health authorities (RHAs) and the municipalities. While the role of the State is to provide national health policy, to prepare and oversee legislation and to allocate funds, the main responsibility for the provision of health care services lies with the four RHAs and the 430 municipalities. Overall responsibility for the health care sector rests at national level, with the Ministry of Health and Care Services (HOD).

Norway's four RHAs are responsible for the financing, planning and provision of specialised care. This includes somatic care and care of individuals with mental health problems as well as substance abusers, along with other specialised medical services, such as laboratory-based work, radiology and paramedical services. There are 27 health enterprises under the four RHAs. 23 of them organise hospitals. 4 health enterprises organise the hospital pharmacies, one for each RHA.

At national level, the political decision-making body is the Parliament. The executive body is the Government, along with the HOD. The responsibilities of the national bodies include determining policy, preparing legislation, undertaking national budgeting and planning and licensing institutions. The municipalities provide primary health care, including nursing care for the disabled and the elderly, while responsibility for specialised health care lies with the RHAs that are owned by the central Government. Dental care is still part of the county's responsibilities.

The health care system is mostly publicly owned, although there are some contracts with private agencies, mainly between municipalities and general practitioners, and between the RHAs and specialist physicians. The HOD provides instructions to the RHAs through a "letter of instruction", which is prepared individually for each of the four authorities and can be seen as a "government supplement". The governance of the municipalities relating to primary health care is, in practice, interplay between a number of different ministries, such as the

HOD, the Ministry of Labour and Social Inclusion, and the Ministry of Local Government and Regional Development.

The Drug Procurement Cooperation (LIS) was established in 1995 by the administrative regions in Norway which are called counties. The counties were the owners of the hospitals until 2002. From that time on the state took over the ownership of the public hospitals. Since the year 2002 the RHAs have been the owners of the LIS. The purpose of the LIS is to form the basis for agreements on purchasing and delivering of medicines on the instructions of the state owned hospitals, and thereby reduce the costs.

Table 1.1: Norway – Key data on in-patient care, 2000 and 2004–2008

In-patient care	2000	2004	2005	2006	2007	2008
No. of hospitals	n.a.	n.a.	87	87	87	87
Classified according to ownership						
- thereof public hospitals	n.a.	78	78	78	78	78
- thereof private hospitals	n.a.	n.a.	9	9	9	9
- thereof other hospitals (please specify)	n.app.	n.app.	n.app.	n.app.	n.app.	n.app.
Classified according to subtypes						
- thereof general hospitals	n.a.	78	87	87	87	87
- thereof mental health and sub-stance abuses hospitals	n.app.	n.app.	n.app.	n.app.	n.app.	n.app.
- thereof University hospitals	5	5	5	5	5	5
No. of acute care beds	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
- thereof in the public sector	n.a.	13,039	12,948	12,835	12,518	11,883
- thereof in the private sector	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Average length of stay in hospitals (days)	n.a.	3.5	3.4	3.2	3.1	3.1
No. of hospital pharmacies	n.a.	n.a.	28	29	31	32
thereof no. of hospital pharmacies that serve out-patients	n.a.	n.a.	28	29	31	32

n.a. = not available, n.app. = not applicable

Note: in-patient mental health care in Norway is provided in general hospitals

Source: Drug procurement cooperation – LIS, Samdata

The four regional health care authorities are organised in 27 health enterprises. 23 of them organise hospitals and each health enterprise consists of several hospitals. There are 78 public and 9 private hospitals in Norway which are all publicly funded. There is a hierarchy consisting of 5 university hospitals providing care on the most specialised level and several local hospitals providing care for common diseases.

Approximately half of the hospitals are small (<100 beds), 30 percent are medium size (between 100 and 300 beds) and 20 per cent are large (>300 beds). This is measured by the number of beds in somatic care[1].

Table 1.2: Norway – Pharmaceuticals and active ingredients on market, 2000 and 2005–2009

Number of pharmaceuticals	2000	2005	2006	2007	2008	2009
Authorised pharmaceuticals in total	n.a.	1,838	1,994	2,145	1,882	n.a.
- thereof hospital-only medicines	n.app.	n.app.	n.app.	n.app.	n.app.	n.app.
Active, authorised ingredients in total	n.a.	1,387	1,414	1,449	1,449	n.a.

n.a. = not available, n.app. = not applicable

Source: Norwegian Medicines Agency

There are no medicines authorised for in-patient care only.

Pharmacies, wholesalers and suppliers are allowed to deliver medicines to hospitals. Pharmacies are allowed to deliver any medicine to hospitals and wholesalers are entitled to deliver medicines on a specified list. Suppliers may act as wholesalers and deliver their own products. In practice most medicines are delivered to hospitals by a pharmacy and the medicines are delivered to the hospitals mostly from a hospital pharmacy. There is an agreement/contract between each hospital pharmacy and the hospital.

32 out of 78 public hospitals operate a hospital pharmacy. These hospital pharmacies are in public ownership. The 32 hospital pharmacies are responsible for procurement of medicines, production of ready to use injection/infusion and pharmaceutical services including clinical pharmacies (some clinical pharmacy). The hospital pharmacies differ in size from 5 to 90 employees.

The principal task of hospital pharmacies is to provide pharmaceuticals for the hospital. However, all hospital pharmacies have a department open to the public, mainly to serve patients, hospital employees and visitors. The pharmacies dispense prescriptions and sell health related products.

All health enterprises produce annual reports which can be downloaded from the following websites of the 4 regional health authorities: http://www.helse-sorost.no, http://www.helse-midt.no, http://www.helse-vest.no/, http://www.helse-nord.no/.

[1] SAMDATA Nøkkeltall for spesialisthelsetjenesten 2008, table 34

1.3 Funding

The central Government funds the Regional Health Authorities (RHAs). The RHAs fund the local hospitals. All hospitals are remunerated by a mixture of ex-ante fixed budgeting (60%) and a diagnosis-related group (DRG) system (40%).

Table 1.3: Norway – Health and pharmaceutical expenditure, 2000 and 2004–2008

Expenditure (in million NOK)	2000	2004	2005	2006	2007	2008
Total health expenditure (THE)	124,728	168,237	176,984	186,761	202,928	217,162
- thereof THE public in %	82.5	83.6	83.5	83.8	84.1	84.2
- thereof THE private in %	17.5.	16.4	16.5	16.2	15.9	15.8
THE in hospitals (HOSHE)	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
- thereof HOSHE public	n.a.	65,894	70,223	75,717	83,090	89,281
- thereof HOSHE private	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total pharmaceutical expenditure (TPE)	13,211	16,704	16,971	16,652	16,900	17,100
- thereof TPE public	9,060	9,350	11,905	11,775	11,686	11,970
- thereof TPE private	4,151	4,940	5,066	4,877	5,214	5,130
Pharmaceutical expenditure in hospitals (HOSPE)	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
- thereof HOSPE public	1,462	1,926	2,065	2,757	3,055	3,360
- thereof HOSPE private[1]	n.app.	n.app.	n.app.	n.app.	n.app.	n.app.

HOSHE = total health expenditure in hospitals, HOSPE = pharmaceutical expenditure in hospitals, n.a. = not available, n.app. = not applicable, THE = total health expenditure, TPE = total pharmaceutical expenditure

[1] private pharmaceutical expenditure in hospitals is negligible in Norway. Private hospitals are mainly publicly funded.

Sources: The Norwegian Association of Pharmaceutical Manufacturers, Statistics Norway, LIS and Norwegian Labour and Welfare Organisation

Table 1.3 shows the development of the pharmaceutical expenditure. The major reason for the growth in pharmaceutical expenditure of hospitals was the transferral of the funding of products from the budget of the National Insurance Scheme (NIS) to the hospital budgets in 2006 and 2008 respectively. These products include tumor necrosis factor (TNF) medicines and medicines for the treatment of Multiple Sclerosis (MS) (cf. section 6).

The share of private funding of private hospitals is very low. In 2006 it was less than 1 per cent of total health expenditure in hospitals[2].

[2] Statistics Norway

There are no out-of pocket payments (OPP) for in-patient treatment. OPP are however required for consultations at the hospitals out-patient departments, with private specialists and general practitioners, for out-patient care, X-rays, laboratory tests and pharmaceuticals.

Treatment for patients from abroad is billed to the patient's insurance scheme. There is no particular billing for pharmaceuticals only.

2 Pricing

2.1 Organisation

2.1.1 Framework

The purchasing process for pharmaceuticals used in publicly funded hospitals is co-ordinated by the Drug Procurement Cooperation (LIS) which is the hospital purchasing agency. This ensures that prices for patent-protected medicines offered by the industry to the hospitals are in general lower than the prices offered by the industry for distribution through wholesalers/pharmacies. This may in some cases encourage a lowering of prices for initial treatment in hospital in order to increase the number of patients in primary care being treated with the pharmaceutical in question.

In Norway, almost all publicly funded hospitals are members of LIS. Hospitals purchase pharmaceuticals according to public procurement regulations within their budget. The regional health authorities (RHAs) settle annual framework agreements through LIS and the hospitals' purchases are then considered to be in accordance with this agreement.

LIS knows all prices hospitals pay for medicines. All prices are the same for all hospitals.

The sole pricing policy in Norwegian hospitals is procurement (cf. section 2.2.1).

2.1.2 Hospital prices

LIS negotiates the pharmacy purchasing price (PPP). Delivery costs are included in the PPP. The RHAs or sometimes hospitals decide on or negotiate the pharmacy mark-up. The pharmacy retail price includes 25% value added tax. Other discounts than the ones given in the tendering process are prohibited.

The wholesale mark-up is subject to a separate tender. One wholesaler is selected for providing distribution services to the hospitals, usually for a period of three years. The tender is performed by the Hospital Pharmacies Health Enterprise, on behalf of the four regional health authorities.

The tenders include all publicly funded hospitals, the information on purchasing is therefore available to these hospitals. The exchange of information is organised by LIS. There is no legal obligation for hospitals or hospital owners to publish the pharmaceutical prices or to notify the price to a competent authority. For other comments on the availability and transparency of pharmaceutical prices in the in-patient sector, please refer to section 5.1.

2.2 Pricing policies

2.2.1 Procurement

Procurement for all publicly funded hospitals is done by the Norwegian Drug Procurement Cooperation (LIS). This includes all pharmaceuticals financed by the hospitals and is done on a yearly basis. The only exceptions are solutions and x-ray contrasts where the procurement process takes place every second year. All suppliers, manufacturers and wholesalers are addressed and the Public Procurement Law applies. This law is in line with the European Union procurement law.

The LIS, hospital pharmacies, hospital pharmacists, hospitals with pharmaceutical and therapeutic committees (PTC) and hospital departments are involved in the procurement process.

The assignment criteria are the following:

- price,
- functional characteristics, such as durability and ability to blend,
- packages such as unit-dose,
- labelling (readability, strength specification),
- generic name (according to European Pharmacopoeia),
- package varieties (unity),
- product variety such as administration form,
- formulation,
- strength varieties,
- service such as training (product knowledge) and
- help with medical enquiries and delivery.

There is no bundling of products in the tendering process.

The tenders are published in the Doffin[3] and TED[4] database, due to legal provision.

LIS tenders have given 24% price reduction for the Norwegian hospitals for 2008, compared to the statutory maximum prices. (For information on statutory prices, please refer to chapter 3 in the report Pharmaceutical Pricing and Reimbursement Information, Norway, October

[3] http://www.doffin.no

[4] http://ted.europa.eu

2008.) In the out-patient sector the products are usually sold at maximum prices. The cooperation also contributes to more efficient and better use of the medicines in hospitals. The savings of more efficient use amount to approximately 15% of the total pharmaceutical expenditure.

For the group of tumor necrosis factors (TNF) the discounts range from 5-12%. For the remaining medicines covered by LIS agreements the discounts are 42% compared to the statutory maximum prices in Norway.

2.2.2 Others

In hospitals there are no other pricing policies besides procurement.

3 Reimbursement

3.1 National hospital reimbursement procedure

In Norway there are no country-wide positive/negative lists that apply for hospital in-patient care.

Pharmaceutical expenditure in publicly funded hospitals is covered by the hospital budgets.

Reimbursement in Norway applies only to the out-patient sector. Please refer to the report Pharmaceutical Pricing and Reimbursement Information, Norway, October 2008, chapter 4.

3.2 Hospital pharmaceutical formularies

There are 22 pharmaceutical and therapeutic committees (PTC) established by the hospitals. The PTCs consist of doctors from specialised clinical areas, hospital pharmacists and sometimes specialists in procurement. The PTCs work out a list of preferred products/suppliers. The lists usually include the 300 most commonly used substances with corresponding products/suppliers. The criteria for selecting products/suppliers for the list are the same as referred in chapter 2.2.1. This list is indicative to guide the doctor's choice of products. The doctors may choose other pharmaceuticals for treatment for medical reasons. The lists are updated on a yearly basis. They are available for internal use in the hospital and are not published externally.

The pharmaceuticals on the list are covered by the hospital budgets, in the same way as any other pharmaceutical provided for in-patient care at the hospital.

4 Consumption of pharmaceuticals

In Norway the total consumption of pharmaceuticals is measured by defined daily doses. LIS statistics on consumption in hospitals is based on expenditure.

Table 4.1: Norway – Pharmaceutical consumption, 2000 and 2004–2008

Pharmaceutical consumption	2000	2004	2005	2006	2007	2008
Annual pharmaceutical consumption in total						
in packs	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
in DDD (in Mio.)	1,561	2,169	2,270	2,368	2,485	2,570
In other measures units (e.g. unit doses, please specify	n.app.	n.app.	n.app.	n.app.	n.app.	n.app.
Annual pharmaceutical consumption in hospitals						
in packs	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
in DDD	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
In other measures units (e.g. unit doses, please specify	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

DDD = Defined Daily Doses, n.a. = not available, n.app. = not applicable

Source: The Norwegian Institute of Public Health and Norwegian Pharmacy Association

Table 4.2: Norway – Top 10 pharmaceuticals by pharmaceutical expenditure and consumption 2007 in hospitals

Position	Top pharmaceuticals used in hospitals, indicated by active ingredient, ranked with regard to consumption	Position	Top pharmaceuticals used in hospitals, indicated by active ingredient ranked with regard to expenditure
1	n.a.	1	L04AB01 Etanercept
2	n.a.	2	L04AB02 Infliximab
3	n.a.	3	L04AB04 Adalimumab
4	n.a.	4	L01XC03 Trastuzumab
5	n.a.	5	L01XC02 Rituximab
6	n.a.	6	L01CD01 Paclitaxel
7	n.a.	7	L01CD02 Docetaxel
8	n.a.	8	J01DH02 Meropenem
9	n.a.	9	J01DD01 Cefotaxime
10	n.a.	10	A04AA01 Ondansetron

n.a. = not available

Source: Drug Procurement Cooperation – LIS Statistics

5 Evaluation

5.1 Monitoring

The total national consumption of pharmaceuticals in hospitals is provided from the Drug Procurement Cooperation (LIS) annually by expenditure per active ingredient and expenditure per package per article. The statistics can be given by LIS on request.

The LIS also has the prices the hospitals pay for the medicines. The prices are the same for all hospitals.

The hospitals buy the pharmaceuticals from pharmacies and the selected wholesaler. The pharmacies and wholesaler give statistics on prices, expenditure per article and active substance. The hospital is the owner of the statistics. A computer system (Farmapro) is used by the pharmacies to track supply to the hospitals. The pharmacy can track their consumption of pharmaceuticals for the hospital and each department in the hospital per volume and price at any time.

In Norway the pharmaceuticals are delivered to the hospitals mostly from the hospital pharmacies. There is an agreement or contract between each hospital pharmacy and the hospital. Some hospital pharmacies serve more than one hospital. Smaller hospitals also get deliveries from private pharmacies.

Some hospital pharmacies supply the hospitals with single dose units. Other pharmacies supply the hospitals with a patient labelled dose unit.

There is a pharmaceutical and therapeutic committee (PTC) in almost every health enterprise. The hospital pharmacies are involved in the PTCs.

5.2 Assessment

The Norwegian Knowledge Centre for the Health Services[5] prepares reports concerning cost-effectiveness in use of pharmaceuticals. Specifically this centre has prepared reports concerning cost-effectiveness in the use of tumor necrosis factor (TNF) pharmaceuticals (biologicals) and medicines for multiple sclerosis (MS) for national hospital use.

The Norwegian Ministry of Health and Care Services established the Norwegian Council for Quality Improvement and Priority Setting in Health Care. First and foremost, the Council shall secure a comprehensive national approach to the work on quality and prioritisation. The council does not do health technology assessments.

[5] www.kunnskapssenteret.no

Stakeholders can discuss and deal with key issues associated with quality and prioritisation by their collective participation in the Council. With the Government's National Health Plan for Norway as starting point, they will initiate professional analyses when necessary and assess the various aspects of complex issues. Assessments of patient benefit, cost-effectiveness and total costs will provide an important foundation for the Council's evaluations.

Reports are published which can be downloaded from the website of the Norwegian Council for Quality Improvement and Priority Setting in Health Care[6].

6 Interface management

Interface management between the in-patient and out-patient sector in Norway exists with regard to specific medicines as hospitals pay for medicines that patients need after discharge of the hospital. These medicines include tumor necrosis factor (TNF) medicines and medicines for the treatment of Multiple Sclerosis (MS). The funding of these products was transferred from the budget of the National Insurance Scheme (NIS) to hospital budgets in 2006 and 2008 respectively. This was mainly due to the fact that some products in this field were financed by the NIS and some products were financed by the hospital. This created the economic incentive for hospitals to prescribe products funded by NIS. Also it was an aim to achieve more competition in the area and lower prices.

7 Developments and outlook

The financial responsibility on pharmaceuticals is changing in Norway. Some expensive pharmaceuticals previously reimbursed by the National Insurance Scheme have been transferred to the hospital budgets (cf. section 6). These are pharmaceuticals primarily prescribed by the hospital specialists.

In Norway the hospitals are merged in health enterprises. For instance all publicly owned hospitals in Oslo (Rikshospitalet, Radiumhospitalet, Aker, Ullevål) were merged into Oslo University Hospital in 2009.

The Government is working on a reform for better interaction between the primary and secondary healthcare system. A white paper was presented to the Parliament in June 2009[7].

[6] http://www.kvalitetogprioritering.no

[7] http://www.regjeringen.no/nb/dep/hod/dok/regpubl/stmeld/2008-2009/stmeld-nr-47-2008-2009-.html?id=567201

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Weblinks

Statistics Norway	http://www.ssb.no/en/
4 regional health authorities	http://www.helse-sorost.no, http://www.helse-midt.no, http://www.helse-vest.no/, http://www.helse-nord.no/.
Norwegian Council for Quality Improvement and Priority Setting in Health Care	http://www.kvalitetogprioritering.no
Parliament white paper on a reform for better interaction between primary and secondary healthcare system	http://www.regjeringen.no/nb/dep/hod/dok/regpubl/stmeld/2008-2009/stmeld-nr-47-2008-2009-.html?id=567201
Drug Procurement Cooperation – LIS	http://www.lisnorway.no/sider/tekst.asp?id=english
Norwegian Knowledge Centre for the Health Services	www.kunnskapssenteret.no
Norwegian Institute of Public Health	http://www.fhi.no/eway/?pid=238
Norwegian Pharmacy Association	http://www.apotek.no/sw20139.asp
TED Database	http://ted.europa.eu
DOFFIN Database	http://www.doffin.no
The Norwegian Association of Pharmaceutical Manufacturers	http://www.lmi.no/FullStory.aspx?m=12&amid=31960
Norwegian Labour and Welfare Organisation	http://www.nav.no