6.0 NORWAY

6.1 Pharmacy numbers

Since the introduction of the new Pharmacies Act in 2001, 81 new pharmacies were established in Norway between 1 March 2001 and 1 May 2002; however, six of these subsequently closed. By contrast, in 2000 only five new pharmacies were established.

In May 2002 there was a total of 483 pharmacies in Norway, giving an approximate average of 9,350 inhabitants per pharmacy (geographically this figure ranges from 8,000 – 16,000 inhabitants per pharmacy). At the end of 2000, the population to pharmacy ratio was 11,280:1. The more recent decrease in the pharmacy per population ratio is consistent with the trend that has been observed over the last 12 years, where the number of inhabitants per pharmacy has been steadily declining. For example, in 1990 there were only 320 pharmacies in Norway, with approximately 12,800 inhabitants per pharmacy.

The moderate but steady increases in the number of new pharmacies during the pre-2001 period was mainly due to an increase in the number of branch pharmacies (see below for a description of ‘branch pharmacies’). When the new Pharmacies Act came into force in 2001, Norway had a total of 402 pharmacies: 374 privately owned and 28 hospital pharmacies (26 public and two private hospital pharmacies). Of the privately owned pharmacies, 260 were licensed pharmacies and 114 were branches. (See Table 6.1). Branches are often similar to their parent licensed pharmacy, except that they have restricted space, sometimes shorter opening hours, and they cannot manufacture drugs. Branch staff are employed by the main licensed pharmacy and branches draw upon the services of the main pharmacy, including staff, in cases of leave of absence.

48 The regulatory situation for pharmacies has recently changed in Norway. The new Pharmacies Act, that somewhat liberalised the highly regulated pharmacy sector, came into force on 1 March 2001. With the new legislation only one year old it is still too early to say whether liberalisation will have the expected effects on availability, service and prices. The new Pharmacies Act also allows for the sale of certain OTC-medicines in other shops as well as in pharmacies. There is no single pharmaceutical association in Norway which is mandated to oversee the pharmaceutical profession. Two such professional associations are the Association of Proprietor Pharmacists (NAF) and the Norwegian Association of Pharmacists (NFF). Since 1 January 2001, the authorisation of pharmacists and inspection fall under the responsibility of the Pharmacy Inspectorate, which is part of the Ministry of Health’s Medicines Agency.
Table 6.1. Number of pharmacies in Norway, 1990-2002

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</thead>
<tbody>
<tr>
<td>Pharmacies</td>
<td>259</td>
<td>257</td>
<td>256</td>
<td>254</td>
<td>252</td>
<td>250</td>
<td>247</td>
<td>249</td>
<td>254</td>
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<td>260</td>
<td>353</td>
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<tr>
<td>Branches</td>
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<td>47</td>
<td>55</td>
<td>66</td>
<td>70</td>
<td>78</td>
<td>90</td>
<td>97</td>
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<td>110</td>
<td>113</td>
<td>114</td>
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<tr>
<td>Hospital Pharmacies</td>
<td>19</td>
<td>22</td>
<td>24</td>
<td>25</td>
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<td>28</td>
<td>28</td>
<td>28</td>
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<td>28</td>
</tr>
<tr>
<td>Total</td>
<td>320</td>
<td>326</td>
<td>335</td>
<td>345</td>
<td>348</td>
<td>355</td>
<td>385</td>
<td>392</td>
<td>392</td>
<td>397</td>
<td>402</td>
<td>483</td>
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</tbody>
</table>

Source: Authors’ calculations based on Norwegian Association of Pharmacists (NAF), 2002.

There are two categories of pharmacists in Norway: university graduates (with a MscPharm degree) and pharmacy technicians, who have 2.5 years’ education in pharmacy (there are plans to increase this training to three years).

An accurate figure on the number of pharmacists in Norway is not available but some estimates can be made. In 1990, there were approximately 2000 pharmacists, giving a ratio of 2110 inhabitants per pharmacist; in the year 2000 there were approximately 2400 pharmacists, yielding a population to pharmacy ratio of 1880 inhabitants per pharmacist. (See Table 6.2).

There is a serious shortage of pharmacists in Norway and it is expected that this shortage will affect the speed of pharmacy expansion. The Pharmacies Act reserves the right to restrict the number of licences issued in certain areas if this is deemed necessary to ensure acceptable pharmacy staffing throughout the country as a whole.

Table 6.2. Number of pharmacists in Norway, (estimate) all sectors, 1990-2000

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</thead>
<tbody>
<tr>
<td>Number of Pharmacists</td>
<td>2006</td>
<td>2018</td>
<td>2071</td>
<td>2080</td>
<td>2171</td>
<td>2218</td>
<td>2221</td>
<td>2329</td>
<td>2309</td>
<td>2321</td>
<td>2380</td>
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</tbody>
</table>

Source: Authors’ calculations based on Norwegian Association of Pharmacists (NAF), 2002.

6.2 Restrictions to entry

Under the new Pharmacies Act, there is no longer a national plan and the Ministry of Health no longer assesses the overall need for pharmacies. Thus, the allocation of pharmacies is now left to the market. There are no requirements regarding distance

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49 Pharmacist numbers are calculated from membership numbers published by the Norwegian Association of Pharmacists (2002) and from estimates (e-mail correspondence 22 April 2002) given by Martin Bjerke, the Associations’ chairman. The Association’s membership figures take into account an estimated number of non-members working in the pharmaceutical industry (approximately 200) and the number of pharmacy owners (equal to the number of pharmacies).
from existing pharmacies but there is a restriction stipulating that that pharmacies must be physically separated from a prescribing doctor’s practice.

The new Pharmacies Act contains no incentives to encourage opening pharmacies in remote areas. Operational subsidies may be given under certain strict conditions but only a small number of pharmacies qualify. The new Act does not include any provision for dispensing doctors.

With the liberalisation of the pharmacy sector, one of the fears which arose was that there might be a drain of pharmacists from rural districts to urban areas where an expected sharp increase in new pharmacies was expected to occur. In response to this potential problem, the government contracted with the former state wholesaler, NMD, (now a private chain owned by Gehe) which committed the chain to maintaining pharmacies in Norway’s rural districts. NMD’s main competitor followed suit, committing themselves (from 1 March 2001) to taking over vacant licences within municipalities with only one pharmacy when the current owner resigns (unless there are other interested parties). These contracts are valid for three years. In cases where a pharmacy cannot make a profit, a system of economic support based on subsidies raised from pharmacy annual fees revenue continues to operate (see below).

Because of Norway’s geography, containing small settlements in isolated places, the Medicines Agency may also allow ‘medicines outlets’ in places where this is considered to be necessary to secure access to medicine (evaluation criteria include the distance to the nearest pharmacy and the level of transport services available). These outlets, approximately 1200 in total, are located in shops of various kinds (although some 20 of them have their own premises) and stock a limited range of OTC-drugs. The medicines outlet(s) belong to a local pharmacy, which is responsible for the quality of products and for training the personnel running the outlet. The pharmacy and the municipal medical officer provide the list drugs that will be sold in an outlet. In addition, many of these outlets distribute prescription medicines, which have been forwarded in packages from the local pharmacy, to individual patients.

Mail order to patients is restricted to the local area, i.e. patients in a pharmacy’s geographical impact area may have their prescriptions filled either by a doctor contacting the pharmacy to forward a prescription or patients sending their prescription to the pharmacy and receiving a parcel by mail. Hospital pharmacies are allowed to sell drugs to former patients outside their area when this is considered to be the best option for the patient.

6.3 Restrictions on ownership

The first pharmacy in Norway was opened in 1595. During most of the 20th century, and until the new Pharmacy Act came into force in 2001, all pharmacies (except hospital pharmacies) were privately owned by university graduates with a degree in Pharmacy (MScPharm). However, the government (through the Norwegian Board of Health) regulated who could own a pharmacy, how many pharmacies there should be and where they should be located. No owner-pharmacist could have more than one licence but pharmacists could open branches in places where the government felt there was a need for a pharmacy, albeit one that provided reduced services.
Under the pre-2001 system, pharmacies were individual enterprises with the pharmacy owner having economic and administrative responsibility for the enterprise. A national plan ensured that even small communities would have a pharmacy and the plan restricted the number of pharmacies that could be located in cities. Under this system, when a local government (known as a municipality) wanted a new pharmacy to be established, it would send an application to the Board of Health; the application would include information that appropriate premises and facilities were available for a new pharmacy. There was no explicit policy on location within a given community/local area but populated areas such as shopping centres and busy streets tended to be preferred over locating pharmacies within GP practices.

A progressive fee on annual sales was (and still is) used to ensure a minimum income for pharmacy owners and to minimise the divergence in income between pharmacy owners which otherwise would occur. Based on pharmacies’ annual account statements, a subsidy is granted to pharmacies that do not make a surplus high enough to ensure the owner a reasonable income. Part of the funds created by these fees are used for other purposes such as postgraduate training, part-funding of the Medicines Agency and, latterly, for establishing regional drug information centres and the national forensic laboratory.

The licensing system for pharmacies changed on 1st March 2001. Licences are issued by the Pharmacy Inspectorate, which is located within the Medicines Agency, in the Ministry of Health (previously licences were issued by the Norwegian Board of Health).

A licence is valid for a specified municipality. Before a licence is issued by the Medicine’s Agency, the municipality will be consulted. Conversely, municipalities may initiate discussions with the Medicines Agency where there is a perceived need for pharmacy services in areas that currently lack them. Whilst there is no restriction on who may apply for a licence, people who obtain a licence must employ a licensed pharmacy director with an MScPharm degree. This pharmacist has full responsibility for the professional running of the pharmacy in question. Moreover, the Medicines Agency may grant a licence with attached conditions, e.g. it may attach conditions on cooperation with local health services, opening hours or the provision of pharmacy services to nursing homes.

There is no longer the requirement that a pharmacy owner should have a professional qualification or background in pharmacy in order to be granted a licence. Thus, in principle, anyone may obtain a licence, with the exceptions of pharmaceutical manufacturers, prescribers (doctors, dentists, veterinarians) and their close relatives, or persons close to manufacturers or health establishments treating ill people. The law is very complex on this point and has not been given in detail here.

Under the new Act, companies may also own pharmacies. Currently, 265 (59 per cent) pharmacies are fully owned by pharmacy chains (such as Vitus 99, AllianceUniChem Norway 71, and Apokjeden 95). The remaining pharmacies (excluding hospital pharmacies) are owned by private individuals, and there are a few small chains. As figure 6.1 shows, the pharmacy market is currently dominated by three chains that are owned by the three large European wholesalers Alliance-Unichem, Gehe and Phoenix. The largest of these wholesalers Gehe acquired NMD from the Norwegian government in 2001 as part of the privatisation process and have 52 per cent of the wholesale market (Gehe, 2002). There is a restriction on chain ownership however, no single
chain can own or manage a number of pharmacies whose combined turnover exceeds 40 per cent of the total sales turnover of all private pharmacies in the market; as the figure below shows it appears that Apokjeden is approaching this threshold. Apokjeden was founded in 1995 originally as a buying alliance for member pharmacies and in 2000 entered into an ownership agreement with Tamro Distribution AS that integrated the pharmacies with the wholesaler (Stokke, 2001). Wholesalers such as Gehe have customer loyalty programmes that include purchasing advantages, training opportunities and support in designing and fitting their pharmacies (Gehe, 2002).

**Figure 6.1. Distribution of market share by pharmacy chain affiliation, 2001**

![Distribution of market share by pharmacy chain affiliation, 2001](image)

Source: LMI, 2002

As mentioned above, each pharmacy owner must employ a pharmacist as the director of the enterprise. This person must have a MScPharm degree or equivalent two years’ practice and authorisation. Individuals may only hold one licence at any time, which allows them to run their main pharmacy and up to three branches. Each of these branches must have its own non-licensed qualified pharmacist as a manager. There are some restrictions on establishing branches, with the licensed pharmacy director having to be present for at least half of the branch’s annual working hours. As only a qualified pharmacist may dispense drugs, a pharmacist must be present during the full opening hours of a pharmacy. In Norway, the minimum pharmacy opening hours is 35 hours per week.

Pharmacies may not enter into a contract with a prescriber (GPs, dentists or veterinarians) that would have the effect of a) restricting a patient’s right to the free choice of pharmacy or b) would link discounts given to the prescriber with the value or number of prescriptions received by the pharmacy.

Pharmacies are required to stock and supply, on demand, all medicines with market authorisation in Norway. Pharmacies have a monopoly on the sale of medicine but currently discussions are underway to allow the sale of OTC products in other retail locations ‘to increase availability’. The new Pharmacies Act opens up the possibility of
selling OTC-products in ordinary shops. The original timetable was to allow such sales after the first three years that the new Act had been in operation (i.e. in 2004).

At least 85 per cent of pharmacy turnover must derive from medicines and medical supplies, with 75 per cent coming from prescription-only medicines. The remaining percentage of turnover should derive from goods that have traditionally been sold in pharmacies and conveniently compliment the sale of medicines and medical supplies. However, 1 per cent of turnover should be from products produced within the pharmacy. Estimates in 2001 found that 72.3 per cent of private pharmacy sales came from prescription drugs, 12 per cent non-prescription drugs and 15.7 per cent non-pharmaceuticals (LMI, 2002).

6.4 Restrictions on price

Prescription-only medicines have a maximum price set by the regulatory authority (price to pharmacy and pharmacy sales price). The Norwegian Medicines Agency sets the pharmacy purchase prices as the mean of the 3 lowest prices in a group of Northern European countries. OTC medicines have no price control. Pharmacists are obliged to inform patients about the cheapest alternatives available and, with patient or doctor agreement, they may dispense a different product to that listed in the prescription if there is a cheaper alternative on the official list of interchangeable products. Norway reimburses the cost of medicines for a defined number of diseases, chronic or life-threatening. This means that not all medicines with market authorisation are reimbursed and a medicine may be reimbursed only if used for certain conditions.

The pharmacy margin is digressive and has been reduced every year by the government. From 1999 to 2000 the margin, after director’s salary (defined by the employer) and tax, fell from 3.7 to 3.1 per cent. A dispensing fee per prescribed item is charged and an additional fee is allowed for narcotics and psychotropic medicines. There is a 24 per cent VAT on all medicines. Privately owned pharmacies pay a fee on annual sales to the government. In 2002, this fee was changed from a progressive fee to a flat fee and is currently 1.4 per cent of the pharmacy purchase price of all medicines sold. Pharmacists have the incentive to substitute parallel imports and generics as part of a discount sharing model which allows them to retain up to 50 per cent of the difference between the maximum price and the actual price (Haga and Sverre, 2002).

- References


