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'We are many'

EDITORIAL

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'We are many, we are half', goes the refrain of the Swedish feminist anthem from 1971. When we are many, we can make our voices heard.

Photo: Sturlason

On 23 April 2026, the Norwegian Parliament considered a motion from the Conservative Party (*Høyre*) proposing 'a comprehensive strategy to improve women's health and menopause care' (1). Part of the proposal was that the Government should 'ensure improved and more equal access to treatment for menopausal symptoms, including hormone therapy and relevant medicines through the subsidised blue prescription scheme, where clinically indicated' (1).

At present, hormone therapy for menopausal symptoms under the scheme is subject to stringent criteria, and is generally only prescribed upon individual application to the Norwegian Health Economics Administration (HELFO). Consequently, the vast majority of women prescribed such medications must cover the costs themselves, which is contrary to the principle of access to health care not being dependent on ability to pay (2).

The proposal prompted substantial public engagement ahead of the parliamentary debate. A petition organised by the Norwegian Women's Public Health Association collected more than 90,000 signatures (3), and politicians themselves have spoken publicly about their own symptoms, arguing that action is required (4).

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In the political parties' recommendations ahead of the parliamentary debate, some argued for an immediate expansion of the subsidised blue prescription scheme, while others wanted to further examine the matter (5, 6). The final resolution was that the Government should 'consider how the subsidised blue prescription scheme could be expanded to include hormone therapy for women during the menopause, where clinically indicated'. In other words, the Government was asked to *consider how* such an expansion might be achieved, not to *ensure* that it would happen. It has since been interpreted to mean that any expansion or modification of the scheme will involve priority setting (7). There was also no dedicated allocation included in the revised national budget (8).

Women experiencing menopausal symptoms deserve appropriate care, and there is a consensus that access to necessary medicines should not depend on ability to pay. Yet we are faced with a dilemma: the substantial increase in treatment options combined with the ageing population means universal entitlement to all interventions is no longer feasible. Politicians must therefore undertake the unpopular task of priority setting, ideally informed by clinical experts and the public, before major decisions are made.

Petitions that lead to earmarked funding can have unintended consequences: after women with breast cancer highlighted the excessively long waiting times for breast reconstruction, the then Health Minister allocated substantial funding to reduce waiting times. Unfortunately, insufficient consideration was given to the time required to train plastic surgeons. In the longer term, the number of specialists increased and waiting times fell, but for a time clinicians had to prioritise women requiring breast reconstruction over other patient groups with comparable needs (9).

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Many patients rightly consider it unfair that ability to pay determines access to medical treatment. Some of the most relevant patient populations are people with obesity seeking pharmacological treatment, neonates at risk of severe respiratory syncytial virus (RSV) disease if not vaccinated, and unvaccinated older adults at risk of painful herpes zoster infection (7). By the time next year's national budget is presented, more groups will likely have been added to the list.

In a democratic society, everyone has the right to make their voice heard, but some undoubtedly find it more difficult to be heard than others. Individually, rare diseases affect very small numbers of patients. Nevertheless, between 190,000 and 320,000 Norwegians have a rare disease (10). They cannot

assume that politicians will have personal experience of their condition. Nor can many of them realistically expect to gather signatures from nearly 100,000 of the electorate in support of *their* particular illness.

Politicians therefore need to reflect carefully, take a broader view and keep their ear to the ground before allocating significant public resources to the treatment of menopausal symptoms – not simply because we are women, but because 'we are half' of the population (11).

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