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GENERAL PRACTICE IN NORWAY - INCREASING ITS POPULARITY?

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After several years of reduced recruiting of young doctors to primary care, and at the same time experienced GP's leaving their posts to go into hospital medicine or other medical specialities, Norway is now experiencing a growing number of doctors wanting to work in the field of primary care.

This is probably due to several factors. Without doubt an increased educational capacity combined with a reduced growth of doctors posts in hospitals, plays an important role.

However, the introduction of a personal list system for general practice, is a major contributor to the growing interest in general practice.

The system was introduced the 01.06.01. The Norwegian GP's voted in favour of it by a substantial, but not overwhelming majority in the autumn -00.

The new system has, among other things, created better possibilities for the GP's to limit their work loads, increased the overall incomes for most of the GP's, and reduced the influence of the local municipalities upon the daily work of the doctors.

Today more than 99 % of the population, and 99% of the GP's, are members of the personal list system, and generally both doctors and patients are satisfied.

Only a few years ago Norway had a deficit of approximately 600 GP's, but today there are only about 100 lists vacant although several new posts for GP's have been established during the last years. During the last 2 years there have been an increase of about 400 GP's.

The new system also implies a shift from salaried employment in the municipality to private practice. There is no doubt that this increases the GP's income, autonomy, working conditions and overall satisfaction with his or her job. Out of approximately 3800 GP's, the number of colleagues who are employed by the municipality and payed on a regular basis has been reduced from nearly 800 to 300 during the last few years, and even before that the number was declining.

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Today most Norwegian GP's have their main income through 3 different sources; one part being paid directly from the patient, one part from the national insurance system depending upon what kind of procedures the doctor do for the benefit of the individual patient, and one part as a per capita fee depending upon how many patients the doctor is taking care of on his or her list. Only a few doctors, and mainly in the rural parts of the country, are paid only on a regular fee from the municipality regardless of the work he or she is actually doing.

Introducing the new system has not been without serious complications. Although the availability of the individual GP has increased substantially over the last year according to the economic figures of the national health insurance, the lack of availability of GP's still is the main criticism of the system, as it also was before the system was introduced. This especially applies to emergency situations, and mostly to the situation in our largest cities, Oslo in particular. There have been some unfortunate incidents, even with fatal outcomes, where there has not been the needed clarification as to who is responsible for taking care of the patient. One major reason for this, is that the municipality of Oslo abandoned their long time system of an emergency ward over night, and left all the responsibility with the GP's, although this was not a part of the national deal.

The overall impression is, however, that the new system is very positive evaluated by patients and doctors, both GP's and hospital staff.

After several years with great interest and intense debates in the GP's general assembly, the last years meeting attracted only half the members that usually come, and the press suggested that the GP's are now pleasantly satisfied.

Lets hope this is not the case, and that the GP's and our organisation is able to keep up the pressure and still improve our working conditions and economical interests as a movement from the ground plan.

There are several scientific evaluations about different aspects of the new system to come, and we are looking forward to seeing these and hopefully rectify any negative effects seen.

Until the last few years, we have had a system of small medical districts for emergency wards, organized and financed to a large extent by the municipalities.

This arrangement necessitates a high frequency of afternoon- and night duties for the individual doctor, especially in the rural parts of our country. This has been a major negative factor as to recruiting doctors to primary care in rural parts. We have recently reached an agreement with the Government that merges several small emergency districts into larger ones, thereby drastically reducing the number of night duties for the individual doctor. Although the Government has promised to cover any increased costs, many municipalities are very sceptical as to whether their whole expense will actually be covered.

In some districts therefore the new system was introduced with great succes both among doctors and patients, but in other parts of the country no change has taken place.

We have a good system both profesionally and financially for CME, and most GP's participate in this.

The GP's organization in Norway, Apf, has recently produced a policy document on primary health care for the elderly, especially those who are not able to live in their homes anymore. In this document we try to state what medical and staff recourses are actually needed for optimal care and treatment of these patients.

We are now working on a similar document for the children and young adults. In this document we propose that people up to 20 years of age should have doctor visits free of

charge, and should not have to pay for the preventive pill. There is a tendency in many parts of Norway to introduce special public health centers free of charge for the young adults between 13 and 20 years of age in the same way that we have maternal and child health centers. In our opinion this is not the right way to go. We think it is important that the young generation establish a contact with a GP who takes care of all their health needs, and not split this up among different actors in the field of health care.

There is also a discussion in Norway about the extent to which GP's should be engaged in the treatment of drug addicts, especially those in the need of methadon-treatment. We feel that the GP's should not be left with the whole responsibility, but be supported by many other sources within the health care- and social working system to a larger extent than what is the case today.

Over the last 10 years or more, there has been a continuous discussion about the system that controls the way the GP's send their bills for patient treatment to the National Health Insurance. Although there without doubt have been exposed some doctors misusing the confidence this way of being paid is based on, we are very concerned about the way the control is carried out. We have a lot of examples showing an accidental and unfair treatment of individual doctors. This has also played a negative role in the recruitment of GP's during the last years.

The last few years in Norwegian have been years of many, and important reforms in the public health sector.

The latest reform is that of changing the ownership of the hospitals from the counties to the state. This has greatly changed the structure of hospital medicine and negotiating partners, and to some extent also changed the places where important priorities are made. As a consequence of this, The Norwegian Medical Association has been forced to make a lot of internal changes, many of which are taking place currently.

It has not been easy for the GP's to obtain the influence we think we should have in the process of changing the national structures of hospital medicine.

For the first time since world war II, the Norwegian Medical Association has elected a GP as the president of the organisation. This is Dr. Hans Kristian Bakke, the former leader of the Norwegian GP's organisation, Alment praktiserende lægers forening (ApIf), and a former UEMO delegate. This is a matter of great pride for the Norwegian GP's.

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