



EUROPEAN UNION OF GENERAL PRACTITIONERS
UNION EUROPEENNE DES MEDECINS OMNIPRATICIENS



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Many of the items reported last year are still the matters of most concern for The Norwegian Medical Association and The Norwegian Association of General Practitioners.

The personal list system, introduced in June 2001, still seems to function well. Scientific evaluation is still ongoing, and the reports are generally very positive.

We still need more GP's both in the cities and especially in the rural areas. Although there has been an increased number of medical students educated over the last years nearly every student starts to work in hospitals after end of education. The hospitals engaged nearly 400 young doctors every year. Since June 2001 we have had nearly no increases in GP. In the same period the hospitals have been more specialised. The gape between primary health care and secondary health care is increasing, and the continued work with elderly, chronically and psychiatric patients has been placed in primary health care. .

The trend of changing small medical districts for emergency wards into larger ones, is slowly, but steadily gaining terrain, thereby reducing the amount of night duties for the individual doctor. However, in some parts of the country, especially in rural regions, the process still is slow, and frequent night duties is a very negative factor for recruiting GP's to these areas.

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Another problem for recruiting GP's to rural areas is that the communities, because of bad economy, tend to remove some of the stimulating factors that were introduced some years ago to tempt doctors to come to work there.

GP's income in Norway is partly a grant from the community depending on the number of patients on the list, partly a sum paid by the patient and partly a reimbursement from the Government depending on what medical procedures the doctor carries out. Over the last 5 years there has been a tendency for the Government to increase the amount of money paid by the patient, and reduce the reimbursement accordingly. GP's very strongly oppose this because it makes seeing a doctor more expensive for the patient and reduces the intended economical stimulation for the GP's to carry out certain procedures that should take place in general practise. Last year there was 5% increase of the economic burden for the patient, in spite of a massive protests from patients, patient organisations, and the Norwegian Medical Association. It is important for us to keep up the pressure on the Government to secure the economical burdens for our patients are not too high.

In 2003-2004 we have experienced a large reform in that the ownership of hospitals has been moved from the counties to the state. As a consequence of this, there has been a tendency to centralize hospital wards into larger units and remove several medical services from smaller hospitals. Although there are several good, both professional and economical reasons for this, many GPs, especially in rural parts of the country, feel uneasy about the increased responsibility for emergency treatment and transport over longer distances, hereby placed on them. This new organisation of secondary health care still strives to find its optimal functioning form.

An internet based communication systems between GP's, hospitals, information systems and other actors within the field of medical care has been introduced. The discussion of how to share the costs of this has not found solution accepted by the GPs., and the implementation of the system is a slow matter.

There has been considerable concern among doctors, especially GP's, that the extended control system, intended to control the expenses of the National Health Insurance, as well as the amount of medical information requested by private health insurance companies could violate the professional secrecy of doctors. It is an important task for our medical organisation to secure that confident medical information about our patients is not spread unnecessarily.

There is still considerable concern among GP's about the growing amount of GP tasks being left to other health workers with shorter education like nurses, physiotherapists, chiropractors, etc. Many GP's feel that our medical field is being fragmented and partly taken away from us, thereby reducing the GP's ability to know, and coordinate all medical services to our patients.

This seems to be in great contrast to the idea behind the personal list system recently introduced and so strongly advocated both by the public and our politicians.

Over the last years a substantial work has been done to improve the quality of GP's specialization program. The Norwegian Medical Association wants that every GPs having a list population out to be a specialist in GP, or takes place in a education program to be a specialist in GP.

After some years of planning and discussions, there has been a large change of structure within The Norwegian Medical Association. Most important is the formalisation of two different sections within the association. One section deals with economical factors, working conditions, health policy strategies etc, and the other section deals with medical skills, education, researched and similar items. The structure has been made in a way we hope will enable the two sections to cooperate closely, but still have the necessary autonomy to act within their own field of interest.