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Framework to-do for GPs

EDITORIAL

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The general practitioner crisis is over. Now comes the battle over the framework of a system that requires stability.

Photo: Sturlason

In the spring of 2025, Jan Christian Vestre (Labour Party) will present a new white paper (1) on the general practice service. At the core of this is the general practitioner (GP) scheme.

The scheme links nearly 5.5 million Norwegians to one of the country's 5379 GPs (2). Just over 136,000 people are not currently registered with a GP – nearly half the number a few years ago (3). Furthermore, this year's Health Policy Barometer also shows that Norwegians' satisfaction with their GPs continues to grow (4).

This positive development follows several years of crisis. The transfer of some responsibilities to primary care created an unmanageable workload for many. Now the number of GPs is increasing, largely due to a much needed financial boost to the scheme. In the spring of 2023, for example, basic funding was increased by more than NOK 700 million (5), and attractive grant schemes have been introduced for specialty registrars in general practice (6).

> ***«This year's Health Policy Barometer shows that Norwegians' satisfaction with their GPs continues to grow»***

However, not everything is rosy. The average number of patients per GP is falling (2) and is now at a record low, with fewer than 1000:1. This means that even more GPs need to be recruited for the system to survive. Both the current

health minister and previous holders of the post have declared that the GP scheme needs to be modernised. Key topics have included interdisciplinarity and digitalisation, buzzwords that never fail to win applause. Most people lose interest when the discussion shifts to the distribution of grants and activity-based funding. However, it is changes in this humdrum area that are likely to have the greatest impact on daily life moving forward, both for doctors and patients.

To understand this, we need to examine the structure of the GP scheme. Four out of five doctors are self-employed and receive public funding in the form of basic grants (7). It should be noted that there are significant geographic variations. In medium-sized and smaller municipalities, the number of permanent positions is now increasing (5). Doctors are being enticed to rural areas with promises of high earnings.

A major challenge facing the authorities is the management of GPs. How can the self-employed doctors' activity be regulated? In 2023, GPs in Norway cost the country NOK 11.8 billion in basic grants and reimbursements, compared to NOK 8.2 billion in 2019 (7) – an alarming increase.

On closer inspection of the figures, we find that around half of the cost increase is due to the increased funding for the scheme – the long-awaited boost to the basic grant that likely saved the scheme (5, 7)). The rest is an increase in reimbursements due to GPs' higher activity levels, with video consultations making up a significant portion of this. Nevertheless, the GP scheme as a whole costs barely NOK 3000 per capita annually (7).

A total of 31.8 % of GPs' income stems from grants, which are allocated based on patient numbers. The remainder of their income is activity-based; government reimbursements and out-of-pocket expenses from patients (7). This means that the more self-employed GPs work, the more they earn. This distribution is deliberate, and tests of different funding models prior to the introduction of the GP scheme in 2001 revealed that a 30/70 split in favour of activity was the most effective approach. A refined fee system has been developed, where the authorities incentivise desired behaviours and various procedures. As a result, investing in equipment can increase income, with the added benefit that more of the patient pathway can be handled in primary care. Furthermore, it is economically rational for the GPs to be efficient with their time. The societal benefit of this is better access to GP services.

There is reason to believe that the Ministry of Health and Care Services now wants more control over GPs. To achieve this, a change in the funding structure has been proposed (8). Consideration is being given to increasing the grant proportion, initially to 50 %, but the overall budget will remain unchanged. This would lead to lower fees, reducing the financial reward for work performed.

> ***«This will result in a potential erosion of the Norwegian GP scheme as we know it»***

It is not difficult to imagine the effects of this. An increase in the proportion of GPs' income derived from grants will make it financially advantageous to maintain high patient numbers and minimise patient contact, for example with video consultations. Some of the GPs' tasks might be transferred to other healthcare personnel, which could challenge the doctor-patient relationship. We could call it *interdisciplinarity*. There will also be less of an incentive to perform procedures to address problems presented at the GP's practice. Consequently, the number of referrals to the specialist health service will increase. Ultimately, this will result in a diminished understanding of patients, a fragmentation of responsibility and the potential erosion of the Norwegian GP scheme as we know it.

> ***«If hospital waiting times are to be reduced, investing in GPs must surely be one of the most effective strategies»***

A paradox that has become more apparent the longer I have worked as a GP is that the Norwegian government's interest in exploring international models for general practice is directly proportional to the fascination with the Norwegian system among my international colleagues. While we are looking further afield, others are looking to us.

The combination of financial incentives for efficiency, a willingness to find local solutions, and a pro-active medical association has resulted in satisfied patients and a high-quality service. Working as a GP is exhilarating, and we have a system that the health service can be proud of. It is not unreasonable to claim that 90 % of patients visiting a GP complete their treatment in primary care. If hospital waiting times are to be reduced, investing in GPs must surely be one of the most effective strategies.

My impression is that most GPs are not driven by money, but by an interest in their profession and pride in doing a good job. However, it is naive to think that changes to an established, popular and predictable funding model will not affect the way we work. The ramifications will impact more than just the general practice service. What we need is not a GP revolution, but a white paper that supports a measured evolution and ensures predictability for the GP scheme.

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